POPULATION CONTROL IN INDIA

(POLICY - ADMINISTRATION - SPREAD)

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Foreword

The need to check population growth as a precursor of economic development has never been in doubt in this country and, notwithstanding certain aberrations in the implementation of the policy recently, it stands to reason that the programme will continue with vigour and with a definite time-bound target. Meanwhile, considerable literature is bound to grow analysing, evaluating and criticising the population control policy and programme so as to assess the actual achievement against cost and target.

This book by Prof. Barnabas is an important addition to this growing literature. It evaluates the population control policy in the last 30 years or so and particularly brings out the administrative apparatus at work in implementation of this policy. In one chapter Prof. Barnabas gives in some detail the success of the programme in certain specific sectors—the army, the railways, the posts and telegraphs etc. While the information that he has collected is itself revealing, it also shows how success has been achieved in these sectors with quiet efficiency, with none of the aberrations in enforcement so much in evidence of late elsewhere in this regard.

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Preface

This book has come out of a report prepared in 1975 at the request of the Asian Centre for Development Administration, Kuala Lumpur, when the Centre was making a comparative study of the family planning programme in South-East Asia with particular reference to its administrative aspects. The ACDA had given a uniform frame of reference for all the reporting countries to facilitate international comparison when necessary.

Considerable revision has since been made in the original text to include the later developments in the family planning programme in India, figures have been brought up-to-date and a whole chapter has been added on the 'spread' of the programme in the country. The present book, in short, traces the history of India's population control policy over the last 30 years and analyses the achievements. The administrative structure of the programme has been described in detail. The management methods, the personnel training and the population control research programme have also been dealt with.

The book is based mainly on documentary evidence. Discussions, however, were held with officials of the Family Planning (now Family Welfare) Department both at the Centre and in the States. Some of the research institutions were visited and the staff in these institutions were interviewed.

Based on the documents and interviews with the officials and research workers, an effort has been made to assess the progress of population control in India. The focus of analysis with regard to achievement is the implementation system. The relationship between population growth and levels of development has also been considered. Some suggestions have been

made which could help in a more efficient implementation of the programme. A post-script has been added to bring the situation up-to-date.

The book has a chapter on 'Family Planning Programme in Government Organisation'. This is based on a paper prepared for a seminar called by the Ministry of Labour, the then Department of Family Planning, and the ILO in December, 1976. The seminar was postponed and has not been held so far. The information contained in the paper and used here has a bearing on the question of the extent of acceptance of family control among the more 'developed' population.

I would like to take this opportunity to thank the several people whose help has been invaluable in writing this book. Dr. I.J. Whang of ACDA provided the stimulus for its publication. He was the coordinator of the studies in the various countries. Mr. B. Mahadeva, Director, ACDA and Dr. A.M. Banerji were involved in the discussions and made useful suggestions. I would like to thank them for giving me permission to publish the book as a whole. The ACDA has published an abridged version of the paper in one of its publications. Prof. Ishwar Dayal, the then Director, IIPA, encouraged me by making funds available for travel and research. The officials in the then Department of Family Planning and those in the States were extremely cooperative and provided the latest information regarding the programme. The discussions were free and frank. I would also like to acknowledge the help rendered by the Research Assistant, Miss Kusum Bhargava, in preparing the manuscript.

I would like to thank Mr. R.N. Haldipur, Director, for publishing the manuscript through the IIPA.

The help of the Editorial Section and particularly Mr. N.R. Gopalakrishnan in bringing out this publication is gratefully acknowledged. I hope this book will give a broad view of the total programme as it is operating in the country, and the factors relevant to its implementation.

—A. P. BARNABAS

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CHAPTER 1

Introduction

PURPOSE AND METHOD

In trying to assess the family planning programme on a global level Barelson said "We are thus in a mixed position, that is difficult to appraise with confidence so much having gone on in so many places, in so few years. We do not altogether know where we are. We are trying to digest our experience to date, to assimilate to balance the achievements and the shortfalls to appraise alternatives even as we seek to go beyond what we do now." The situation in India which was the first country to introduce a family planning programme could be said to be the same. It is a huge undertaking in India. Substantial information is available on various aspects of the programme. The data need to be put together to get a comprehensive view of the programme. Such an effort would not only indicate "where we now are" but also through up the gaps in our knowledge which are relevant in effective management of the family planning programme. Further, it could provide some insight regarding the alternative approaches to be considered for a more effective implementation of the programmes.

The book will consider briefly the following aspects: The context, the history and development of the programme, the organisational arrangements, human and material resources, the evaluation and the feedback system, the training and research programmes.

The information has largely been gathered by documentary evidence which consisted of research studies, reports and articles in professional journals. The officials of the Centre who are at the helm of affairs were interviewed, particularly to get their assessment of the progress of the programme as well as the

future plans. To make the analysis more concrete the States may be classified on the basis of achievements as high performance, medium performance and low performance. More specifically an effort has been made to scrutinise the situation in two States—Tamil Nadu where performance has been higher than the all-India average and Uttar Pradesh where the performance has been lower. The States were visited for brief periods and the officials concerned interviewed.

THE CONTEXT

To gauge the importance of the programme it is necessary to understand the background within which the programme operates. The concern for achievement (which in itself can be an important variable in performance level) is dependent on the stress that is felt with regard to a particular situation. The population of India in 1974 was about 560 million. While it has 2.4 per cent of the world's physical area and 1.5 per cent of the world's income, it has 15 per cent of the population in the world. The growth rate has been increasing and in the decade 1961-71 it reached 24.8 per thousand. As at present 21 million babies born every year at the rate of one baby for every 1½ seconds. The death rate is 14 per thousand giving a net addition of 13 million per annum—more than the population of Australia. The fertility is 2.7 per cent which is lower than the most Asian countries where it is between 3.1 to 3 5 per cent. The increase in growth rate is due to a sharp decline in the death rate—from 27.4 per thousand in 1961 to 14 in 1971. The life expectancy has risen from 32 in 1952 to 45 years in 1971. For the 13 million person added to the population the following additional resources are needed:

Schools	—	126,500
School teachers	—	372,500
Houses	—	2,509,000
Cloth	—	188,774,000 meters
Food	—	125,453,000 kilograms
Jobs	—	40,00,000

To add to magnitude of the task is the diversity of the country.

Each State is almost a country in itself. The State of Uttar Pradesh has a population of 88 million (which would make it the 7th largest country in the world). There are 340 districts and 5200 blocks (which are administrative units created when the Community Development Programme was launched). While the dominant religion is Hindu (82.7 per cent), there are substantial number of Muslims 11.2 per cent (about 77 million), Christian 2.6 per cent, Sikhs about 2 per cent. The tribal population accounts for about 7 per cent of the total population. The literacy rate is low being 29.35 per cent. The ratio of women literates is about half that of men (19 and 39). The income per capita is Rs. 325 (about U.S. $45). It is estimated the newspapers reach about 12 per cent of the population, films about 20 per cent. Only about a 4th of the 560,000 villages have a community listening sets.

The proportion of persons in the age group 0 to 14 in the total population was 42 per cent according to the 1971 census, while the age group 15 to 59 accounted for 52 per cent of the population. Six per cent form the older age group that is 60 and above. The sex ratio has been declining from 946 females to 1000 males in 1951 to 930 in 1971. About 80 per cent of the population live in rural areas the majority of whom are dependent on agriculture for their living (cultivators 52 per cent, agricultural labourers 31 per cent). In the urban areas the occupations are household industry (5 per cent), transport, etc., (10 per cent) and other services (25 per cent). The density of the population is 178 for the whole country. There are wide inter-State differences in density. The highest density among the States is in Kerala (549) and West Bengal (504) as compared to 94 in Madhya Pradesh, 75 in Rajasthan, 62 in Himachal Pradesh and 31 in Nagaland.

ACHIEVEMENTS

To measure the achievements in a programme like family planning is difficult. Quantitative aspects can be indicated. But that may not tell the whole story. The Fourth Five Year Plan had laid down the objective in specific terms to reduce the birth rate from 39 per 1000 in 1968 to 32 per 1000 in 1973-74. The

death rate was expected to decline from 14 to 9 per 1000 during the same period. Thus the estimated population growth rate of 2.5 per cent during the Fourth Plan (1969-74) is expected to decline to 1.7 per cent by 1980-81. For achieving this objective the operational goal was to protect 28 million couples in the reproductive age (15 to 44). To achieve this, 15 million sterilisation both male and female, and 6.6 million IUCD insertions had to be made. Apart from this 10 million people had to use the conventional contraceptives. The total number of acceptors of the various methods in family planning programme has been rising from year to year. The number of sterilisation in 1966-67 was about 8 90,000. Whereas in 1972-73 it was 3,200,100. The number of conventional contraceptive users has gone up from about 464,600 in 1966-67 to 2,316,506 in 1972-73. There has been fall in I.U.D. insertions from 909,726 in 1966-67 to 353,162 in 1972-73. (The causes for this will be gone into later). The percentage of the achievements for the country as against the target set, are: sterilisation 55 per cent, IUCD insertions 37 per cent and use of contraceptives 54 per cent. There is wide variations in the performance in different States as well as in rural and urban areas. In Tamil Nadu, the percentages were 68, 32 and 37 respectively as compared to U.P. where it was 37, 30 and 25. The birth rate was 37.2 per cent in 1971 for all India. It was 31.2 per cent in Tamil Nadu and 44.6 per cent in U.P. For the urban areas the birth rate is about 30 whereas for the rural areas it is 39. Only about a third of the States have achieved the birth rate of around 32 per cent per thousand. The number of couples protected is 15 per cent. Although the target was to protect about 30 per cent. In U.P. the percentage was 7.7 while in Tamil Nadu 17.7. It must, however, be noted the percentage of couples protected has gone up from 4.4 million in 1966-67 to 15 million in 1972-73. The number of births averted is estimated at 13 million in 1972-73 as compared to a little more than 1 million in 1966-67. The overall picture is that the birth rate has not been reduced to the desired level. As against the planned protection of 28 million couples only about half that target has been reached.

CHAPTER 2

Policy and Programme

CHANGES IN STRATEGY OVER 25 YEARS

The trends of the population growth have been a concern to the people of India for over a long period. As far back as 1935, the national planningcommittee under the presidentship of Pandit Nehru declared itself in favour of birth control. However, the Government as such did not undertake any programme on its own till after the attainment of independence. The First Five Year Plan (1951-56) recognised that rapidly growing population would jeopardize the programme of raising standard of living. Hence the programme for family planning was included in the plans. The aim was to reduce birth rate. The approach was exploratory. The effort was to make people aware of the problem and provide devices and services for planning the family. Some experiments in the rythm method of the planning family were conducted. In the Second Five Year Plan (1956-61) more emphasis was laid on the programme with a larger outlay of funds. The programme included education, provision of services, training and research. Facilities for voluntary sterilization and increased availability of conventional contraceptives were provided. Research activity was extended to include study of demographic aspects, communication and attitudes in addition to the bio-medical areas. During the decade 1951-61, the approach was essentially clinical expecting people to come to the clinics for advice and services. This was buttressed by some mass information and publicity efforts.

The census of 1961 was an eye opener. The widening gap between the death rate and birth rate was a matter of serious concern. The Third Five Year Plan (1961-66) envisaged a vastly expanded programme. During this period it was

increasingly realised that the progress of plan development was likely to be neutralised by population growth (G. Narain). "There was a shift from the restricted and the narrow clinical approach to one of extensive community extension involving functional education, provision of facilities near the homes of the people, advice on the largest possible scale and a wide-spread popular effort in every rural and urban community" (country paper). There were organisational changes so as to put into effect the new approach. The Department of Family Planning was established in the Ministry of Health. From 1966-69 the National Development was planned on a year to year basis. The prior importance given to the family planning programme continued with further intensification of the strategies adopted in the Third Plan.

In the Fourth Five Year Plan the Family Planning Programme continued to retain its status as one of the major national priorities. During the period the effort was to further consolidate and intensify the structure and the components of the programme. The two components which indicated a change over the earlier periods need to be specified. The objectives were laid down in more concrete terms, *viz.*, the reduction of birth rate from 39 to 32 per thousand during the plan period. To achieve this, targets were assigned to the district and the primary health centres through the States. "Efforts were made to achieve enduring results through appropriate education and motivation together with the full involvement of general health service in the programme (Fifth Plan Document, p. 239). This led to a greater integration of health, family planning and maternity and child health activities. The strategy in the Fifth Plan is a continuation as well as an change over the earlier phases." The Fifth Plan approach will be, to increasingly integrate family planning services with those of health, maternity and child health and nutrition. The efforts will be made to convert more and more vertical programme workers into multipurpose workers (Fifth Plan, p. 241). The continuity is in setting specific targets. The change is in reorganisation of the personnel at the primary health centres to be involved in the total health programmes. Another difference is, the programme will be implemented as a truly family welfare-oriented programme by extending the scope and coverage of

immunisation and nutritional prophylaxis components so as to help reduction of the infant mortality rate and to improve the nutrition status of children in 0—6 age group (Fifth Plan, p. 241). The strategy in the Fifth Plan is a consequence of the evaluation of the programme. "The non-attainment of the stipulated reduction in birth ratio may largely be due to the highly ambitious targets set earlier coupled with insufficiency of efforts to project the programme throughout the country as a mass movement and the rather slow build up of the infra-structure in some populous regions for extension efforts and provision of services" (Fifth Plan, p. 240).

What is the context within which the family planning programme is conceived in relation to the rest of the policy and programmes of development—Is the family planning programme an integral part of the development programme or is it a programme *per sè*? In either case there are implications for implementation. India seems to have gone through a full circle in its analysis of the relationship of the family planning programmes to national development policies. The attention of Pandit Nehru was drawn to the rate of increased population after the 1951 census by the then Registrar General. Pandit Nehru, however, believed that the nation's chief problem was that of underdevelopment rather than over-population. "It was not that Nehru was opposed to fertility limitation but that he and other policy makers saw the population issue as a diversion from the more fundamental challenge of economic development. They held that expanded production was the fundamental issue in raising the level of family planning; family planning could only remove of constraint. The gravious weight of that constraint was not removed ..." (Mendolbaum, 5). This belief explains rather the soft pedalled approach in the First and Second Five Year Plans. The Third Plan came in the wake of 1961 census. It revealed a much higher rate of population growth than was anticipated and the damaging effort on the income per capita was noted. This gave a new orientation to the role of population control. The Third Plan categorically stated "the objective of stabilising the growth of the population over a reasonable period must therefore be at the very centre of planned development" (Third Plan, p. 25). This policy revealed "being shocked out of academic tinkering

with a population problem..." (V. K. R. V. Rao). The budget allotment increased from Rs. 49.7 million in the Second Plan to Rs. 269.7 million in the Third Plan. The approach continued to be favoured in the Fourth Plan period. "If population keeps growing rapidly, the major part of the investment and national energy and effort may be used up for merely maintaining the existing living low standards".

Removal of poverty and attainment of self-reliance are the two strategic goals which the country has set for itself in the Fifth Plan. The plan goes on to say the demographic perspective for the *reference* period underlines the enormity of the task before the country (Fifth Plan, 1). Over a 12 year period an increase of 124 million is estimated. It is of the utmost importance that the family planning must achieve that much success as has been assumed.... (Fifth Plan, p. 2). The plan is based on the underlying assumption of the decline in fertility rate. The evaluation of the family planning programme indicates that only about 50 per cent of the targets has been achieved. There is as indicated earlier wide variations in the different regions of the country in the performance with regard to family planning programme. Greater success seems to have been achieved where the development process is ahead of the other areas. This has caused some re-thinking in the strategy of the plan. At the Bucharest Conference, the Health Minister stated "we are quite clear that fertility can be effectively lowered only if family planning becomes an integral part of the broader strategy to deal with problems of poverty and underdevelopment." On another occasion he said "it (family planning programme) must become a part of our total approach to socio-economic problem....it is not possible any longer to look upon family planning programme standing in isolation...." Such a view is likely to have an impact in the operation of the programme in the Fifth Plan.

It may be of interest to note the statistics with regard to some related aspects of development to population. The income per capita has risen from Rs. 253 (U.S. $34) in 1951 to Rs. 349 (U.S. $47) in 1971 (according to 61 prices). The food availability in 1951 per capita was 395 grams per day. It was 469 in 1971. The literacy rate has risen from 16.6 per cent in 1951 to 24.0 in 1961 to 29.3 per cent in 1971. The growth rate of

literacy was 40 per cent in 1971 as compared to 22 per cent in 1961. At times the increase in food production and income per capita has been used as an argument against family planning programmes. Some have even suggested without the increase in the population size there could not have been increases in food or per capita income. To counter this, estimates can be indicated as to the possible higher rate of development if there was less population. Moreover such an argument does not take into consideration the impact on housing, water supply, education, employment, etc.

In the Fifth Plan the need for effective integration of family planning programme into the comprehensive development effort of the country has been recognised. Consequently a minimum needs programme is planned for. Such a provision is expected to help in sustained economic development. The elements in the provision for a minimum needs programme are elementary education, rural health, nutrition, drinking water, provision of house sites, slum improvement, rural roads and rural electrification.

Some have raised the question as to whether India does have a clear population policy (Bose, Dandekar, Kavoori). A comprehensive population policy would include four aspects : birth rate, death rate, migration and distribution of the population. The Indian family planning programme is essentially concerned with a control of birth rate. It hardly takes into account the other three aspects. The death rate has come down from 27.4 in 1951 to 15.1 in 1961. It has gone further down since then. Some efforts are being made to control rural migration to urban areas but not as a part of the population policy. The redistribution of the population is not a feasible suggestion both from political and sociological aspects. Hence the crux of the problem in the population policy has to be reduction of birth rate. The department of family planning is clear as to its charter, *viz.*, to reduce birth rate to a given level. It is assumed that in doing so there would be an improvement in the quality of the life of the people as reduced birth rate would allow for increased consumption levels.

CHAPTER 3

Programme Objectives

In the Fourth Plan, Family Planning was accorded the highest priority (Fourth Plan, p. 391). The aim in specific terms was a reduction of the birth rate from 39 to 25 within the next ten to twelve years (*i.e.*, by about 1980). In order to achieve this, a concrete programme was drawn up for creating facilities for the married population during their reproductive period of bringing about:

(*i*) acceptance of the small size family,
(*ii*) personal knowledge about family planning methods, and
(*iii*) ready availability of supplies and services.

The need for a "package" approach to help in family planning was realised. The objective was to increase the integration of health, family planning and maternity and child health activities. The Fifth Plan takes into account that the birth rate has gone down by 4 points only, *i.e.*, from 39 to 35 per thousand in the Fourth Plan period. "In the light of this trend, it does not appear feasible to bring the birth rate down to 25 per thousand population by the end of 1980-81" (Fifth Plan, p. 240). It appears more realistic that reduction of birth rate by 5 points, *i.e.*, the level of 30 per thousand population by the end of Fifth Plan (1979) and further 5 points to 25 per thousand of population by 1983-84 (Fifth Plan, p. 240). To achieve this, during the Fifth Plan, 40 to 42 million eligible couples will have to be provided protection. This would call for a higher level of performance as compared to the Fourth Plan period. The anticipated targets are:

1. 18 million sterilisations;
2. 5.9 million I.U.D. insertions; and
3. 8.8 million users of conventional centraceptives.

PROGRAMME ACTIVITIES

As the Fourth Plan has just ended, it would be useful to look at some activities undertaken by the Government to achieve the targets set for family planning. Essentially, the "cafetaria" approach continued to be operative in the Fourth Plan. That is, all methods were propagated, *viz.*, the use of conventional contraceptives, I.U.D. insertions and sterilisations both male and female. Oral pills are also being tried out on a pilot project basis in some areas. The other activities included the organisation of mass vasectomy camps in several districts. The effort was to have an intensive campaign over a period of time. The camps accounted for 2 million acceptors of vasectomy during 1972-73. The conventional contraceptives (condoms) which are called "Nirodh" are produced in a factory in India. The present output capacity is around 144 million pieces in a year. The plan is to double the production. There are three schemes through which these are distributed: Free distribution in the family planning centres, stocking with depot-holders who are given free supplies but are allowed to sell at a nominal rate of 5 paisa per packet and the commercial scheme where the shop-keepers are supplied at the rate of 7 or 8 paisa per pocket, but can sell at 15 paisa per packet.*

Some of the new schemes started during the period included *post partum* scheme (*i.e.*, providing family planning methods to cases enrolled for obsteric and abortion) intensive district scheme and the immunisation and nutritional prophylaxis scheme.

Apart from these direct activities, there were some steps which can be termed as supportive of the programme. "The Medical termination of pregnancy act" was placed on the Statute Book on 1st April, 1972. The measure is designed to liberalise the provision for the resort to abortion in cases where there is undesired conception. Another supporting measure was to raise the legal age of marriage. The marriage age of girls at present is 16 and the proposal is to raise it to 18 years.

A provision of cash incentives was an important factor in the programme. Rs. 85 was given to a volunteer for vasectomy and

* The actual cost is about 35 to 45 paise hence it is heavily subsidised. There has been an increase in the rate recently.

Rs. 45 for volunteers to tubectomy (part of it was to defray their expenses). Apart from this the motivators were also given some cash emoluments. This activity has been often reviewed. The major motivation for volunteers seems to be the financial incentive. A study (Saxena) in U.P. indicated that only 2 per cent were motivated to undergo the operation because of the desire to limit the family size, whereas 62 per cent because of incentives.

A CRITICAL APPRAISAL OF PERFORMANCE

A quantitative analysis of the performance has been given earlier. The number of sterilisations up to March 1973 were about 11.6 million, I.U.D. insertions, 1.43 million and the users of C.C. 15.36 millions. By and large, the criteria for measuring the achievements has been quantitative. There is a growing concern that such information does not provide an adequate measure of the real situation. The qualitative aspects need to be looked into. The picture that emerges is not very encouraging when viewed thus.

Although the "cafeteria" approach is the policy, yet the dominant item so far has been sterilisation. It is well-known, however, that a major portion of those who underwent vasectomy had wives in the age group of 35 and above. From the data available from a study of the vasectomy camps, it appear that 60 to 70 per cent of the acceptors' wives had at the time of their husbands undergoing operation, 4 or more living children (V.K.R.V. Rao, Mukherji and Saxena). Calculating the number of birth rate up to the age of 44 it was seen that sterilisations prevent an additional birth of 15 to 20 per cent only. If the number of vasectomies done in the camps in 1971-72 and 1972-73 are not taken into account, a gradual decline in the number of vasectomies performed is to be discerned.

Early in the Third Plan, it looked as though a solution to the family planning problem had been found in the I.U.D. The acceptance was high (813,000 in 1965-66 and 910,000 in 1966-67 in the early stages but it has declined to 453,000 in 1972-73. Apart from this, there has been a large number of reversals. It is estimated that of the 4.65 million insertions, only 1.43 million are retaining it (*i.e.*, only 3 out of 10 persons who have the

I.U.D. insertions are protected) (V.K.R.V. Rao). The major cause for the reversals which is as much as 60 to 70 per cent (P.E.O. Mohapatra) is due to lack of after-care facilities. Pain, bleeding, rejection, backache, have been the complaints of a large number of women. The Lippes loop has been mostly used so far. There are further experiments on this. The growing feeling among the officials of the family planning department is that the Copper T is the most suitable for India. The cost, however, will be prohibitive as each piece will cost about U.S. $2.

The use of condoms has been showing a steady increase except for 1972-73 over 1971-72. However, it is difficult to indicate its impact as regularity and continuity are necessary. The oral pill (steroid) has not been stressed very much. There are at present 319 pilot projects. Of the 74,500 women who had adopted this method less than half (about 32,000) are continuing. From one study (Mohapatra, *et al*) it was found that about two-thirds had some complaint or the other. Nausea, vomiting, dizziness, were the most frequent complaints. The other complaint mentioned fairly frequently was menstrual disorders (15% had more than three complaints).

The reasons given for the careful approach in the introduction of the oral pills are:

1. The cost (it costs about Rs. 30 per month *i.e.* U.S. $ 4);
2. Lack of sure and reliable knowledge of the after-effects;
3. The need for a dependable delivery system; and
4. The discipline required (which is lacking particularly among rural women) to take the pills regularly.

Efforts are being made to produce pills at a lower cost. There is also in experimental stage a "morning after" pill "Cent Chromin". It is claimed to have no ill effects. The results of the experiment are encouraging. There is another device known as "Cent Square" developed also by Central Drug Research Institute. This is a paper "Loop" impregnated with urea. This is to be inserted before coitus. This is also at the pilot study level. If these succeed, there could be a technological breakthrough.

The number of illegal abortions taking place in India is estimated at 4 million per year (Kaul, Dijkstra, D'monte). The law now allows for abortion if there has been a failure of the contraceptive methods From April 1972 (when the Law was passed)

to September, 1973, only 41,000 abortions were carried out. Out this about 40 per cent (17,000) were done in one State—Maharashtra.

Not all doctors seem to be willing to perform this operation. Moreover, it would take time before abortion is a socially accepted method of birth control.

It is admitted by the Government itself that the intensive district plan tried in 17 district has not brought about the expected results. The idea of the intensive district scheme seems to have emerged from the "package programme" districts for improving agricultural production. About third of the district produce most of the food requirements of the country It was, therefore, felt that an intensive effort must be made to provide sufficient inputs through a package of practices in those districts so that maximum production can be reached. It is estimated that about one-third of the population of the country lives in 51 districts. In the family planning programme there was no "package" of practices. The effort was to intensify the propaganda with more family planning assistants. One other factor which may explain the lack of success may be that there was no specific criteria with regard to the choice of the district. There is some rethinking on this. Districts with high density and high growth rate are being considered for the intensive district scheme It may also be that density and growth rate may be taken as variables for setting up experiments.

There have been some depth studies of the vasectomy camps (N.I.F.P. Series 13, also Saxena). The median age of the husband undergoing vasectomy in Tamil Nadu was 40.5 whereas in U.P. it was 40.8. The age of the wife was 34.4 in Tamil Nadu whereas in U.P. it was 37.1. In either case, the remaining reproductive years were very few. In U.P. 40 per cent of the women whose husbands had undergone vasectomy had had no children for six years. The chances of their having more children was doubtful. The number of living children in Tamil Nadu was 2.7 and in U.P. 4.3 when the sterilisation operation was performed. In both the States, more than 90 per cent were either cultivators or agricultural labourers. Among those who underwent the operation, 57 per cent in Tamil Nadu and 64 per cent in U.P. were illiterate. While the average annual income in U.P. was Rs. 1560, it was only Rs. 527 per annum in

Tamil Nadu (for the volunteers). The level of income is all the more significant in view of the fact that the Tamil Nadu income per capita is higher than that of U.P. It would be obvious that vasectomies while contributing quantitatively does not have the desired effect when analysed from a qualitative point of view or in absolute terms of bringing down the birth rate. There is now a de-emphasis on the mass camp approach. Only "mini" camps would be organised at the primary health centre. This would allow for a better control of the volunteers and also of follow-up.

The Fifth Plan indicates that there is a rethinking on almost all aspects of the programme activities—sterilisation, I.U.D., condoms, mass camps, pills, etc. This partly is the impact of the feedback from the field. In part it is due to the studies done by the demographic centres and independent agencies and criticism in the public and the press. This is an indication of the sensitiveness of the department to public reaction.

The low performance may also be due to the lack of motivation among the workers of the family planning programme. There seems to be a general concern in the administrative circles regarding the low morale of the personnel. This was true both in Tamil Nadu and U.P. But the situation in U.P. seems to be more difficult. A recent study in U.P. shows that 48 per cent of the workers did not follow either the calendar of work or the methodology. Thirty per cent did not stay in the area assigned to them. Twenty per cent did not motivate any couple for any method in 9 months, another 20 per cent motivated only one couple and 40 per cent motivated only 2.5 couples during the period (Pande, Jagannadham). Such a low output raises questions regarding the understanding, commitment and motivation required among the workers. The temporary nature of the job, lack of adequate facilities, lack of proper leadership in the immediate horizons, the non-acceptance of the workers by the rural people (in a few cases, the workers have even been threatened) have not made for enthusiasm among the workers. It is also possible that the workers did not quite understand their own role properly. The concern for achieving the targets set by the Centre has not provided sufficient opportunities for them to be innovative in their approach to the people. Understanding commitment and motivation is seen at the Centre, and

to some extent at the State level. At the State level, questions were raised regarding the method of formulation of policy, setting of targets, etc. But this was more due to a concern for the lack of rapid progress in the programme rather a disenchantment with the programme.

CHAPTER 4

Administrative Set-Up

A complex organisational structure has been evolved involving the Cabinet Ministers at the Centre and the Chief Ministers in the States in the apex body responsible for national policy making to administer the programme. The administrative organisation also attempts to keep close liaison with the State and involve the State Ministers in the National policy-making. The administrative structure of family planning follows the pattern of general administration and can be best understood if seen at various levels.

AT THE CENTRE

The apex body at the Centre is the Cabinet Committee with the Finance Minister as Chairman. The other members are the Union Minister of Health and Family Planning, Ministers of State for Finance, Social Welfare and Health and Family Planning, Home Affairs and the departments of Electronics and Scientific and Industrial Research. This Committee is mainly concerned with the formulation of a national policy and review of the progress from time to time.

Besides the Cabinet Committee, there is a Central Family Planning Council under the Chairmanship of the Union Health Minister. Minister of State for Health and Family Planning is the Vice-Chairman. The membership of this body is broad based and includes State Health Ministers and representatives of various All-India organisations and other departments connected with the family planning work. The composition of the body itself suggests that there is an effort to infuse in the policy-making and planning, those people who are connected

with the actual implementation of the programme so that it lends realism by feeding the experience gained in the process.

The administration of the programme is in charge of Additional/Joint Secretary in the Ministry of Health. There are two other officers who are almost parallel in the hierarchy, *viz.*, the Family Planning Commissioner and the Marketing Executive. Till recently there was a fairly clear distinction between the technical wing which functioned under the Commissioner and the administrative wing which functioned directly under the Additional Secretary. Recently the Commissioner appointed belongs to the administrative cadre and all the persons in charge of the various sections report to the Commissioner directly who in turn reports to the Additional Secretary. The Marketing Officer is incharge of the distribution of the condoms and he is assisted by deputies at various levels including Market Research Manager, a Publicity Executive.

The Family Planning Department has a large number of sections and each is in charge of either a Director or a Deputy Commissioner. These are policy, mass-media, progress, training and research, transport and management. These are assisted by either Under-Secretaries or Assistant Commissioners. The Marketing Division in the Department deals with procurement and distribution of Nirodh and other conventional contraceptives including commercial sale of Nirodh. The policy division assists in the formulation of policy, planning and coordination. The management division is responsible for procurement of various items required under the programme and their distribution, transport development, etc. The Mass Education and Media Division is entrusted with formulating the strategy for motivation and development of mass media and extension activities at the national level. This division also looks after the Mass Mailing Unit which is responsible for printing and distribution of material to different readership groups. The Perspective Planning, Evaluation and Intelligence Division is responsible for collection and compilation of statistics relating to the progress of the programme and data required for policy making.

Apart from this there are 7 regional directors of family planning in different regions of the country for coordinating the work with the State Governments. Each of the directors is

in charge of two or three States. It is now planned to have one regional/field director assigned to one State so as to bring about more effective coordination between the Centre and the State.

STATE LEVEL

Like the National Cabinet Committee there is a State Cabinet Committee with the Chief Minister as the Chairman and Ministers of Health, Finance and Welfare as members for formulation of broad policies and programmes and reviewing their progress from time to time. Again for associating various voluntary organisations and concerned official agencies, the department of health is assisted by State Family Planning Council/Board and the Action/Implementation Committee.

As far as the execution of the programme is concerned it is looked after by Director of Health Services who is assisted by a State Family Planning Bureau headed by the State Family Planning Officer. The State Family Planning Officer is assisted by Assistant Director of Health Services, Incharge of Operation, Planning and Training Division, Mass Education and Communication Officer, Administrative Officer and Statistics, Demography and Evaluation Division.

DISTRICT LEVEL

District Family Planning Bureau is responsible for the planning and implementation of the programme in the districts. The District Family Planning Bureau is headed by District Family Planning Officer. Although the programme operates separately under the District Family Planning Officer the Chief Medical Officer (or Civil Surgeon) is in overall charge of the programme. The major divisions in the district are administrative, education and information and field operations and evaluation.

City Family Planning Bureaux is provided for cities with a population of 200,000 or more. There is a gradation of the staff according to the population. There are also urban family welfare centres covering different areas of population ranging from 10,000 to 50,000. At present there are 1990 urban family

planning centres (1241 run by the State and Central Governments, 345 by local bodies and 333 by voluntary organisations).

BLOCK LEVEL

The primary health centres with a population of 80,000 to 100,000 which were opened under Community Development Schemes are the base from which family planning programme activities are undertaken. There are 5243 of them at present. The medical officer at the Centre is in overall charge of the programme. There is an Assistant Surgeon (male or female) who is directly responsible for the family planning activities. For the whole block there is an Extension Education Officer. He has under him four health and family planning assistants who are responsible for a population of 20,000 or so. Their major job is to educate and motivate people with regard to family planning. There are 3,33,048 sub-centres, one for a population of about 10,000. An auxiliary Nurse and Mid-wife assisted by an attendant is in charge. She is supervised by a Lady Health Visitor who is in charge of a population of 40,000.

The primary health centre as well as the ANMS has stocks of contraceptives with them which are to be distributed to the people free of cost. The primary health centre is equipped to perform vasectomy and tubectomy operations. Some of the primary health centres (one in four) will be equipped to undertake medical termination of pregnancy operations. At present they are done only at the district hospitals. To augment the services available at the district and the peripheral level, there were 857 mobile units (366 for sterilisation and 491 for IUCD). As the facilities have increased at both levels, the number of mobile units were reduced to one per district.

ACTION IMPLEMENTATION COMMITTEES

In order to review periodically the progress of the family planning programmes action implementation committees have been set up at the block, district and the state levels.

Non-officials are included in the Committees at the block and the district levels.

SOME PROBLEMS

Three factors may be noted with regard to the Administration : (*i*) It is a State imposed programme thereby restricting the participation of voluntary organisations. (*ii*) Family Planning Programme operates as a vertical programme (*i.e.*, the administration is directly from the State to the block level) and operates in isolation to general administration including health administration and programmes. With the introduction of multi-purpose scheme this difficulty may be overcome. (*iii*) The Ministry of Education is not involved in this programme. If such education is to be imparted in schools and colleges, active participation of the Ministry of Education would be required.

SOME COMMENTS

One of the most significant decisions made by the Government was to consider family planning programme as a part of health problem. Finkle suggests that this had major consequences affecting the strategy, structure and performance of the Indian programme.

1. The responsibility for the programme was vested in the Ministry of Health.
2. Control over the vital aspects of the programme was retained by the States.
3. Delivery of family planning services was restricted by reliance on the facilities of the general health care delivery system. According to John P. Lewis "it left family planning lodged in what, in the eyes of the most observers remains one of the weakest functional cadres in the Indian Administrative System, most hesitant in effecting expeditious bureaucratic clearances, most subservient to the Finance Ministry and one in which enervating frictions between administrative (Generalists) and technical (Medical) personnel already were a long standing tradition" (quoted by Finkle). The last seems to have deepened with the appointment

of a generalist as family planning commissioner—a position occupied till recently by a technical person.

Health being a concurrent subject the actual implementation of the programme is left to the States. The Centre can only make funds available, offer to train personnel and guidelines for action (Finkle). In other words, the Centre had no effective control over the programme. If some States were indifferent the Centre could do little to bring them into line.

Bose (Jagannadham) sums up the major disadvantages in the present system of family planning administration as follows :

1. The programme is entirely financed by the Central Government and therefore, there is no financial commitment on the part of State Governments. This would mean that the States were mostly interested in getting money.
2. The States do not have the financial and administrative flexibility to modify the national family planning programme to meet their requirements keeping in mind the demographic, economic and social situation in their own States.
3. The expenditure on Family Planning is a part of the plan expenditure and the programme is temporary though there is a commitment on the part of the Centre for the next 10 years. This hampers the recruitment of staff on permanent basis.
4. The family planning programme is an appendage of the health programme.

All these have had a bearing on the implementation of the programme.

THE ORGANISED SECTOR

The organised sector includes all those bodies—Governmental, Semi-governmental and non-governmental which have organised themselves for any specific purpose whether the trade, industry, provision of essential services, or the management of an office. Some of the governmental ministries have what might be termed a 'captive' audience. The Department of Family Planning is making intensive efforts to raise the interest of those

ministries which have a large number of workers. Some of the ministries (for, *e.g.*, Railways, Defence) also have hospital facilities. To motivate these ministries to undertake family planning programme the Department has been giving funds which would enable them to employ extension workers to motivate the employees. The Department has also been financing the staff of the Family Planning Centres. The most important ministries for which funds are made available are Railways, Defence, Post & Telegraphs and Mines. The Railways have 400 hospitals. It has 69 family planning welfare centres, 97 hospitals are supported by health units and MCH centres. A grant of Rs. 4.5 million was made available to the railways. During the year 1972-73 the railways unit performed 17,631 sterilisations, 3,183 IUCD insertions and enlisted more than 100,000 contraceptive users.

The Ministry of Defence has 134 family planning welfare centres. During 1972-73, 10,288 sterilisations were performed and 3,752 IUCD insertions were made. The grant to them was Rs. 2.5 millions. There are 7 dispensaries of the P & T Department who have added family planning components in the last couple of years. Among the Coal Mines 8 centres have been opened. The work has yet to get intensified. The grant at present to the family planning centres of the Coal Mines is Rs. 400,000.*

A chain of family planning welfare centres had been established by the Central Government for the benefit of government agencies. The welfare officers have been appointed as depot holders as well (*i.e.*, to stock condoms). The Central Government Health Scheme Hospitals (at which the Government employees are treated) are being used in the project. If the scheme is successful there will be greater intensification of the programme through the State Governments.

There are about 153 public undertakings under the Central Government whose employees number varies from 100 to 47,000. The Government pays grant in aid to the larger size units for the promotion of family planning. The number of public sector undertaking this programme is rather limited—only about a dozen or so. Efforts are being made to persuade more public undertakings to start these programmes. The State governments have also been requested to intensify the programme

*More details in supplement paper, pp. 56-73.

in the undertakings set up by them.

Tea plantations which employs large number of women has been another area where special schemes have been instituted. In addition to the usual government compensation additional incentives were given by the Tea Association. The acceptance rate up to 1969 was 57 per 1000, for sterilisation 13 per 1000 (both higher than national rate) bringing down the birth rate from 43.4 to 25 per 1000 in Assam, from 35.1 to 22.5 per 1000 in West Bengal states (Chatterjee and Singh). The number of reversals of the IUCD seem to be few. It was not possible to definitely determine the causes of this. A better follow up might explain the phenomena.

Another scheme tried in some of the southern Tea Estates is "no baby bonus". The company paid a bonus to the women workers every month if they were not pregnant. If they got pregnant they forfeited the accumulated bonus. Another experiment is being conducted in two districts (one in Kerala and one in Tamil Nadu) by providing integrated services such as Balvadis (child welfare centres) for plantation workers. A grant of Rs. 1.2 million has been made for this experiment.

Some of the industries have set up their own programmes of family planning. The employers' association and the trade union workers have been approached. In 1973 "All-India Workers Committee" was formed after a conference of the trade union leaders. The Committee would advise the Government with regard to the family planning workers in industries.

There is no gain saying that the organisations mentioned do have a clientele which is readily available. While programmes have been in operation for some time no evaluative studies have been undertaken. The indications are that the programmes in these sectors is catching on.

VOLUNTARY ORGANISATIONS

A programme which requires a change in the values, beliefs, attitudes and orientation of the people requires dedicated workers. The voluntary organisations tend to have workers who are highly motivated. Moreover in a democratic set-up voluntary organisations have a role to play in bridging the gap between the government and the citizens as well as trying out

innovative approaches.

Briefly stated the voluntary organisation can perform the following tasks : (*i*) They can mobilise public support and cooperation needed for the acceptance of family planning programmes. (*ii*) They can act as an agent of change by building pressure groups and mobilising public opinion needed for initiating and effecting structural changes. (*iii*) They can provide service network needed to popularise the programme. (*iv*) It can undertake experimentation needed for developing new techniques and programmes. It may be mentioned here that the Family Planning Association of India was instrumental in getting the programme of family planning accepted in the First Five Year Plan.

TYPES OF VOLUNTARY ORGANISATIONS

The existing voluntary organisations working in the field of Family Planning can be placed into four categories : (*i*) Those which are exclusively working for promoting the programme of family planning like the Family Planning Association of India, Planned Parenthood of India, Population Council and Family Planning Foundation. (*ii*) All the welfare organisations at the National, State, District and Panchayat levels engaged in social work. They have taken up Family Planning work alone with their other welfare and promotional activities. In this category we may include the National Organisations like the All-India Women's Conference, the Bharatiya Grameen Mahila Sangh, the Women's Council, the Y.W.C.A., the Y.M.C.A., the Red Cross Society and Central Social Welfare Board. (*iii*) Professional Associations engaged in the task of promoting Family Planning. In this we may include Indian Medical Association, Christian Medical Association of India (it has recently entered this field. Its family planning project has a membership of about 250 mission hospitals), Bar Associations, Trained Nurses Association of India, etc. (*iv*) Besides these, there are a wide variety of organisations, which have taken up the cause of promoting family planning work, considering the urgent need of this programme. In this category we may include the Trade Unions, Youth Organisations, Cooperatives Panchayats.

DIFFICULTIES OF VOLUNTARY AGENCIES

Although the role of voluntary agencies has been well recognised, they have to work under many handicaps:

(*i*) The feeling of aloofness and lack of mutual understanding hampers proper integration of the work between official and non-official agencies.

(*ii*) Inflexibility of the grant-in-aid pattern and the tardy methods of release of grants create misunderstandings between the official and non-official agencies. The organisations which receive the government grant are so much tied down with the accounting of the grant that real purpose is lost and the programmes suffer considerably. The agencies are also uncertain about the continuation of their work for lack of timely release of the funds. Grants for the most part are earmarked for the salary of staff and equipment. The grant admissible for administrative purposes is much less than the administrative expenditure of governmental agencies. In theory 25 per cent of the grant sanctioned is to be released early in the year and another 25 per cent later. The balance 50 per cent, however, to be released only after the audited statements for the year are produced with a utilisation certificate for the full amount due. But this is only on paper. In actual practice, sometimes the whole year passes by without grants. The majority of the institutions find it difficult to function under the present circumstances. At present only 401 Family Planning Welfare Centres are being run by voluntary agencies, and they are under heavy financial strain.

(*iii*) Some of the organisations have grown so big that they have developed bureaucratic rigidity which does not permit innovation and experimentation.

The efforts of the voluntary agencies have been "so limited and diffuse, their workers so few, their funds so small as to make them appear restricted to doing local good deeds rather than being capable of national political influence" (Mandelbaum). "Nevertheless, they have a great potential. The difficulties indicated are not beyond solution. Family Planning has to become a national movement and it must involve mass

participation not by the 'Mass Camps' technique, but the voluntary organisations functioning at the smallest area and population levels" (V.K.R.V. Rao).

PEOPLES' PARTICIPATION

The decision to limit the size of the family and to adopt a particular method to do is of the people. People have become aware of the programme, but not fully of the services available. In urban areas many voluntary organisations are functioning to enrol peoples' participation. In rural areas, the two organisations through which peoples' participation can be got are the panchayats and cooperative societies. The performance of panchayats is not uniform in the country. In Tamil Nadu, there was a more positive attitude to using the panchayats as compared to U.P. The most effective use of panchayats seems to be made in Maharashtra, where the panchayat institution are involved in the total development process. There is also greater delegation to the district level.

The P.E.O. study says that not much progress has been made in the involvement of the village leaders. The leaders have favourable attitudes to family planning. Programmes in which the leaders would be given more information about the methods of family planning need to be instituted. A high percentage of the rural people had heard of the programme from others in the community. The leaders need to be induced to provide comprehensive information deliberately. Such an effort should further the programme. The Department is attempting by various means to involve the panchayat leaders.

CHAPTER 5

Allocation of Resources

FINANCIAL RESOURCES

In a country where resources are limited, the allocation of resources can be indicative of the importance attached to particular programmes. The outlay in the First Plan (1951-56) was Rs. 6.5 million for family planning programmes, of which only Rs. 1.45 million was spent. During the Second Plan, only about 45 per cent of the budget amount was spent. (Outlay Rs. 49.7 million, expenditure Rs. 21.4 million). The programme really got off the ground in the Third Plan, when out of an outlay of Rs. 269.7 million, Rs. 248.6 million was spent. During the year 1966-69 there was no plan in operation and these years have been termed as interim years. During this period, the expenditure on family planning was Rs. 704.6 millions against a budget of Rs. 829.3 million. The outlay in the Fourth Plan (1969-74) was Rs. 3100 million, the amount spent up to the March 1973 was about Rs. 2800 million. Two aspects stand out. There has been a continuous increase in the outlay to the family planning programme. The expenditure has also been on the increase. However, the total amount spent is always less than the allocated amount. In the Fifth Plan, the outlay is further increased to Rs. 5160 million.

As the programme is centrally sponsored all the expenses incurred even by the States are borne out by the Central Government. The pattern of the infrastructure which the Central Government will support is laid down. As the number of workers is dependent on population, the population size can be considered to be the broad basis for the allocation of funds to the States. If the States want to make any changes, they could

do so at their own cost. Only Tamil Nadu spends Rs. 10 million more than Central Government grant. The amount is used mostly for higher rate of incentives.

The Indian family planning programme recognises eight broad functional areas of costing. The Table given below shows the amount allocated under different heads and its percentage to the total budget.

(1) (2)	*Total Allocation in Fourth Five Year Plan (million rupees)* (3)	*Area Allocation as per cent of Total Outlay* (4)
1. Services including among others: (*a*) static sterilisation units and beds, (*b*) family welfare planning centres and PHC, (*c*) rural sub-centres, (*d*) urban family welfare planning centres, (*e*) post-partum centres, (*f*) intensive district programmes, and (*g*) selected area programmes.	2,448.20	77.72
2. Training including: (*a*) regional family planning training centres, (*b*) central family planning field units and central training institutes, (*c*) training of ANMs and Dais, (*d*) training of lady health visitors, (*e*) training of teaching of family planning in medical colleges, and (*f*) other training programmes.	133.50	4.24

(1)	(2)	(3)	(4)
3.	Mass Education	150.40	4.77
4.	Supplies and maintenance including: (1) manufacture and distribution of commercial contraceptives, and (2) maintenance and replacement of vehicles and equipment.	243.60	7.73
5.	Research including biomedical, demographic and communication research.	70.00	2.22
6.	Evaluation including city fertility surveys, KAP studies, demographic cells at State family planning bureaux.	22.50	0.71
7.	Maternal and Child Health including immunization, prophylaxis and nutrition programmes.	26.50	0.84
8.	Organisation including state and lower levels, technical wings, experimental projects, awards, etc.	55.30	176
	Total	3,150.00	100.00

Note: The total has since been augmented to Rs. 3,300 million. The high investments on items 1, 2 and 3 are obviously intended for several time spans.

It is rather difficult to work out the cost-benefit analysis for a development programme. The factors to be considered are complex and varied. Some of the variables are imponderables (was an acceptor motivated by a worker or self-motivated),

Nevertheless, there is need for a systematic analysis of the cost-effectiveness of the programme which, at present, is lacking. A feeling seems to pervade that the amounts being spent on the family planning programme are not commensurate with the results achieved. There are, however, a few who feel that there is need for a larger outlay (Kavoori and Sien). It is pointed out that the outlay in the Fifth Plan is Rs. 5160 million. The number of couples who are in the reproductive age group is 110 million. Thus it would mean that less than Rs. 10 ($ 1.50) is being spent per couple per year. Such calculations are further indicative of the problems of working out a cost-benefit analysis.

Three classifications under which the cost of family planning programme can be analysed are:

(*a*) Overhead
(*b*) Supportive
(*c*) Operational

The overhead would include administrative, analysis and evaluation and research. The supportive would include information, education, publicity, building, furniture, equipment and training. The operational cost will include:

1. Wages and salaries,
2. Transport expenses,
3. Cost of contraceptives supplies,
4. Payment to motivators,
5. Incentive to acceptors, and
6. Training field staff.

As family planning is one of those fields of public activity where cost-effectiveness studies of its components and also the elements of Programme Planning & Budgetary System technique can be meaningfully applied. These techniques can be applied for:

(*a*) Evaluation of programme effects of inputs (personnel visits, clinics, cost, etc.),
(*b*) Evaluation of intermediate results (number of new acceptors, continuing users, etc.),
(*c*) Evaluation of programme efficiency (relation of intermediate) results to various physical or financial inputs (process evaluation), and
(*d*) Evaluation of effect on the ultimate goal—fertility decline (Mitra).

An exercise of this kind has been attempted by R. Mehta. Such an analysis could have a bearing on policy formulation and decisions. The P.P.B.S. (Programme Planning and Budgetary System) can be used to evaluate the actual programmes, *e.g.*, the money should be spent on camps or producing more contraceptives. The P.P.B.S. can also help deciding the more effective economic mix in the programmes. Once such a projection has been made, the results have to be analysed in terms of performance budgeting. A meaningful analysis of cost is necessary.

INTERNATIONAL AID

The Family Planning Programme in India, is by and large, financed by internal resources. However, about 10 per cent of the resources has come through foreign assistance. The total amount received so far is Rs. 731 million. The major contributions have come from U.S.A.I.D. (Rs 378 million), IDA/SIDA (Rs 230 million); Ford Foundation(Rs.74 million), U.N.F.P.P.A. (Rs. 14 million) and U.N.I.C.E.F. (Rs. 13 million). The grants have been made for specific purposes. The U.S.A.I.D. grant has been for training, evaluation, construction, vehicles, sterilisation camps, innovative and experimental projects and intensive district schemes. The Ford Foundation has assisted the National Institute of Family Planning and the National Institute of Health Administration and Education. The Japanese assistance was for buying condoms, whereas the help from Norway was for post-partum programme. The I D.A. funds were spent in special family planning and nutritional programmes in two States. The U N.F.P.P.A. allotted funds for mass vasectomy camps, while the A.N.M. training in U.P. and Bihar was supported by U.N.I.C.E.F. The W.H.O. provided consultancy services, fellowships and equipment.

The resources allocated within the country allow for keeping the programmes going. It is difficult for allocating funds which fall outside the set pattern. The programme of family planning has to use experimental approaches in many areas. Such experiments require personnel with specialised qualifications, training of personnel, equipment, etc. International

Aid is necessary for undertaking activities other than routine. Funds from outside sources have been used for such purposes and will continue to be sought, for innovative programme. The aid expected in the Fifth Plan period (1974-79) is U.S. $ 90 million from various sources including $ 40 million from U.N.D.P.

HUMAN RESOURCES

The family planning programme is administered by the Ministry of Health in all the States. The workers of the family planning programme are recruited by the States themselves although the funds come from the Centre. But the pattern of infrastructure, the qualifications necessary for each of the posts have been laid down by the Centre. The question of how well the personnel are performing the tasks set, is a difficult question to answer. At the peripheral level, that is the primary health centre, except for the extension educators, specific qualifications are laid down for each of the posts. At the District level, the medical officer is a part of the regular administrative cadre, but the remaining staff is part of the programme. At the Centre and State level, the personnel belongs to the regular cadre of the administration and are posted to various posts for a specific period of time. This policy is not considered as a handicap by the department. The majority of the personnel are non-medical and come from the general administrative cadre.

It must be noted that from the beginning, the implementation of the programme started off with a clinical bias. This has raised questions regarding the roles of the medical, paramedical and the non-medical personnel. Bose (Jagannadham) analyses 13 aspects of family planning programme and suggests only three of them are primarily medical—I.U.D., sterilisation and oral pills. Under non-medical are included motivation, raising the age of marriage, the rhythm method, conventional contraceptives and family planning administration. The contribution and the role of the technicians and the generalists needs a further probe and analysis. The U.N. Mission said in its report: "....the qualifications laid down do not always reflect the nature of the work to be handled in a particular post. This

further emphasises the need for job description. The present practice of relying upon positions for the post of District Medical Officer is a case in point. Since a large part of the District Officers' work is administrative, the recruitment should include persons with the background of administration." The matter is not a simple one. The counter argument is that for a technical programme there is need for an administrator with a technical background. As at present, the situation is *status quo*, *i.e.*, the medical officer continues to be in charge of family planning programme at the district level. For the first time, however, at the Centre, the Commissioner for Family Planning (appointed early 1974) is a non-medical person. "The Mission wishes to emphasise the need for a careful assessment or rather a reassessment of the roles and functions under different categories." Job descriptions for the personnel in the field were worked out sometime ago. There is need to review the situation as the programme is becoming increasingly complex.

The problem of motivation among the workers was mentioned by most of the officials interviewed. Lack of motivation is, therefore, one of the factors in the inability to achieve the set targets. Unfortunately, there is not much empirical evidence with regard to level of motivation among the workers. The discussion with the officials, and occasionally with the field workers suggested some causes which may affect the morale and motivation.

The temporary nature of the programme also seems to have a bearing on motivation. The programme was originally supposed to go on till 1979. It has now been extended to 1984. Even the ten year tenure does not seem to have provided the necessary confidence. The U.N. Mission also referred to this fact and said :

"This practice is a handicap to recruitment and an obstacle to the development of career service." It also said it was understandable that the States do not want to accept for all time the burden of centrally induced expenditure. It suggested providing a permanent status for the programme. There are no clear lines of promotion. It is difficult to provide opportunities for promotion in a given programme with a specified time. Moreover, the operational level is the PHC and as one moves from the PHC to the district and to the State, the organisation

gets rather condensed. The Kartar Singh Committee appointed to look into the reorganisation took cognisance of this problem. In the future planning, there is an effort to provide for promotions to the personnel at the PHC level (*e.g.*, the ANM, could be promoted as Lady Health Visitors and necessary training given). The physicians at the PHCs in charge of the family planning programme are not happy as their specialisation comes in the way of their being considered for posts of medical officers in district which deals with general health. The multi-purpose approach envisaged in the Fifth Plan is likely to change the situation. The physicians will be designated medical officer and specific areas would be assigned in which they will deal with all health problems and also family planning. The need for evolving a meaningful personnel policy within the given constraints has already been mentioned.

According to the statistics available, the percentage of technical staff* in position to the required number is 66 at the State level, 78 at the district level, 56 at the rural level and 65 at the urban level. The number of staff in position has implications for the achievement of the set targets. In Tamil Nadu, the percentage of staff in position at the State level was 87,100 at the district level and 62 at the rural level in March 1973. The situation in U.P. was 93 at the State, 70 at the district and 51 at the rural level. At the urban centre, U.P. has 68 per cent in position while it was 62 per cent in Tamil Nadu. The crucial level is essentially the rural level. The percentage of rural population in Tamil Nadu is 78 per cent and in U.P. it is 86 per cent.

*The technical staff include Health Officers, Director (I.U.D. and Training), mass education officer, demographer, social scientist, assistant surgeon (male and female) A.N.M. Photographer, etc,

CHAPTER 6

Management Methods and Techniques

It is possible to review only briefly a few aspects of management methods and techniques in a short paper. An assessment will be made of the following :

1. Method of setting targets,
2. Methods of communication,
3. Feedback system, and
4. Possibilities of innovation in management techniques.

TARGET SETTING

The emergence of a target-oriented programme in the Fourth Plan has resulted in quantifying the targets to be achieved, *i.e.*, in terms of the couples to be protected, the number of sterilisations to be effected, the number of I.U.D. insertions to be made and the provision for supply of condoms to the targetted number of users. The targets are set on the basis of the population. The Centre sets the targets for the State, the States in turn set the targets for the districts and the district family bureau then allocates the achievements to be attained by each of primary health centres. At the primary health centre level, each of the workers is assigned a specific target. The fact that these targets have not been achieved indicates the need for an analysis of the approach. Many have been critical of setting the targets while others often are wary of the methods of setting the targets. A similar debate took place when the Community Development Programme was launched. It was felt then (it seems to be the continued feeling) that the targets are desirable for providing a sense of direction and purpose to

level, this is a necessity. The anxiety of the workers to achieve the targets may cloud their gaining insights into the real problems of getting the programme going. The worker should be given scope for analysing the factors that make for achievement and those that hinder achievement. Non-achievement need not necessarily be the fault of the workers.

The officials in both the States were rather uneasy about the way the targets were set. They did not consider it meaningful or realistic. The P.E.O. study said that the family planning staff interviewed felt that fixation of targets on population basis only was not realistic. There is an implicit acceptance of the need for targets being set. However, "Factors such as availability of services, the staff-population ratio, the nature of terrain, past achievements, were not generally taken into account (P.E.O. Report). The variables which might affect the achievements need to be considered before the finalisation of the targets. The socio-cultural factors have to be given due consideration. This would include among others the nature of the population (urban, rural, tribal, pattern of occupation, methods of education, the density of population, etc.). Such an approach might mean that the period of achievement of the desired goal may have to be prolonged. This would be better and more realistic than to set targets and not achieve them. The approach would call for:

(*a*) A greater inter-action between the State and the Centre.
(*b*) Between the States and the Districts.
(*c*) Flexibility in setting targets within the overall goals set.

COMMUNICATION

Mass education and media divisions exist both at the Centre and at the State. At the district level and at the block level, specialised staff, equipment, transport, etc., have been provided for educational work. Provision for teaching aids for the workers, as well as extension of mass media through mobile audio-visual aids has been made. A paper prepared by the Ministry of Health says :

"Today, of all the development programmes, family

> planning has perhaps one of the most extensive communication networks in terms of human and material resources even taking into account the fact that the peripheral field staff are not all in position. In addition, the high priority accorded to family planning communication enables the programme to draw upon the resources of other development departments in a major way, during intensive drives and campaigns. The willingness to make such resources available is evidence of a total faith in the power of communication and its media to bring about a drastic change in fertility behaviour. It is in this belief that vast structures have been built up."

There is some awareness of the programme of family planning among 80 per cent of the population (P. E. O., Mukherji, Krishnamurthi, etc.). The awareness itself has not resulted in the adoption of family planning methods—possibly because awareness in most cases has been defined as having heard about the family planning programme. In the ultimate analysis, communication must lead to motivation and action. The fact that only 15 per cent of the couples in the reproductive age group have accepted family planning methods indicates among other things the failure of communication. The need is to analyse the media mix and the content of the message.

From the view point of media mix, a large number of media are used (posters, stickers, bus brands, wall paintings, match box lables, group meetings, apart from radio, films, leaflets, cartoon booklets, press and T.V. (in limited areas). Earlier studies in communication in the area of community development have indicated that the people were motivated to accept improved practices because of personal contact. It would be all the more relevant in a sensitive area like family planning. While media mix and their coordination is relevant and important, the need is for motivating the workers to make as much personal contact as possible. Given the number of people per worker (10,000 to A.N.M.), this is not easy. In the reorganisation plan, it is possible that the number of people per worker will be reduced. The U.N. Mission also emphasised the need for interpersonnel communication. The P.E.O. study indicated that only one third of the respondents interviewed had been contacted by the family planning workers. There was wide variation in the

different areas (ranging from 6 to 50 per cent, with regard to the number of respondents answering in the affirmative about the contacts made by the family planning workers. Only about 9 per cent respondents had contacted the family planning workers on their own.

Another factor that needs some attention is the content of the message. The immediate reaction of most of the people on hearing about family planning is that of "having no more children". The message has not got through the ideas of spacing of children, mother and child health and family welfare. The fear of child mortality is one of the basic factors in having a large number of children. The need for the message is to assure the couples of the survival of the children (the infant mortality rate in India is 140 per thousand. In Tamil Nadu, it is 113 and in U.P. 178). The message has also to respond to social traditions, religious objections, etc. The message has to be credible. Often the films show that a family with fewer children is well to do and happy while the ones with many to be unhealthy or suffering from malnutrition and insufficient clothing, etc. In real life, this is not always the case. There is also the problem of making the message relevant to local conditions and circumstances. The vast diversity of the country is a factor in the barrier of messages getting through. The role of the States mass media wing is important in making the message meaningful at local levels. The use of opinion leaders has to be intensified after they themselves are motivated or convinced. A letter was addressed to all the Presidents of the Panchayats (village councils) by the Prime Minister asking for their cooperation in spreading the message of family planning as a part of the Independence Day Message.

The norm of the small size family has not been emphasised to the extent it needs to be. The target groups for this have to be carefully selected. Often wall paintings or leaflets show one male and one female child as a part of the small size family. Some studies (P.E.O., Mukherji, etc.) have indicated that two sons and a daughter are considered an ideal number of children to have. The desire for a male child is very predominant in the Indian culture. The status of women, the role of daughters, old age security, all have a bearing. Under these conditions, it may be difficult to motivate people for family planning when there

are only daughters. A further analysis and study of this aspect is necessary not only for communication but also for the implementation of family planning programme.

Within the administration, the communication is through annual meetings where representatives from the States and Centre meet. At the State level the meeting of the implementation Committee and occasional workshops provide for communication for passing all the policy decisions to the lower echelons. The Regional Directors who handle two or three States have a role as liaison officers and provide a means of communication. The appointment of the Regional Director to each State is expected to help in greater communication between the Centre and the State. The other methods are routine—letters, circulars, field visits of the officials from the Centre to the State and from the State to the District.

FEEDBACK SYSTEM

The need for a concurrent appraisal of the progress of the programme is appreciated in the department of family planning. There is an evaluation and intelligence cell headed by the Director who is a qualified statistician. Similar cells exists at the State level. The staff consists of a demographer, a social scientist, statistician and investigator, statistical assistant and an evaluation worker (one per two districts). Most of the staff are in position at the state level. The District level is rather poorly staffed. There are only two positions—statistical investigator and field evaluation worker/computer/clerk. At the rural level, there is a computer at the primary health centre. The information is collected at the peripheral level by the family planning assistants and A.N.Ms. The information is gathered through the maintenance of eleven registers. These include monthly progress registers, follow up register, eligible couple registers sterilisation records (male and female), contraceptive records (stocks and issues), I.U.C.D. (case card register), etc. The information collected at the primary health centre is sent to the district bureau, which, in turn, is sent to the State cell of evaluation. The Central Ministry gets its information from the States. The progress reports are analysed at the Centre Statewise every two months or so. The staff at the Centre

review the progress in each of the States and make decisions regarding the steps to be taken to expedite the programme in those States which are lagging behind. The States have been requested to make a similar approach with regard to the districts in their jurisdiction.

There is always a question raised regarding the data collected in the field, particularly by those who are not well-trained. The type of information that is collected is only quantitative and the feeling in the department seems to be that the data on the whole are reliable. No specific evidence is available to show that the information collected is unreliable. The type of date collected by the family planning assistants and the A.N.Ms. would enthuse few research workers to check on. While there is an uneasy feeling about it, there is no alternative but to depend on it. The information collected is essentially quantitative. This by itself does not provide sufficient evidence for taking administrative decisions. There is need to introduce qualitative elements also in the data collected. This at present is partly done by the demographic centres. There is need for a greater collusion between the evaluation cell and the demographic centres so that the data collected is meaningful for analysing the progress of the programme in its total perspective. "The focus of the evaluation of family planning programme at present is on the purposive assessment of the impact of the programme, identification of areas of success and failure and the reasons thereof, and feeding back of this information for modification and improvement of the programme implementation (family planning department paper). The information on three aspects would be needed to evaluate the objective:

1. The performance,
2. The knowledge and attitudes, and
3. The birth rate.

The system as it obtains now does not allow for a full measurement of the objectives. The P.E.O. Report says that there is scope for rationalising records by reducing their number and/or details. The U.N. Report said :

"It is necessary to introduce regular spot checks, supervision and timely analysis of the returns at all levels." There was also a suggestion in both the reports that a uniform approach to record-keeping may not be feasible and meaningful

in all States. The present system provides only quantitative information. Such an analysis does not indicate the areas of success or failures. The impact on policy or changes in the implementation system have been rather limited. Efforts at spot checks have been problematic as there is reluctance among those who have undergone vasectomy operations to admit it. The external agencies have not been used as much for the evaluation of the programme (exceptions being the P.E.O. Report and to some extent the U.N. Report). Universities, social science research institutes and medical colleges could participate more. The few studies made are scattered and do not provide a comprehensive analysis of the programme. The quantitative data is essential but there is need to look at qualitative aspects as well.

MANAGEMENT INNOVATIONS

The Family Planning Department is part of the bureaucratic system of the country. It may be mentioned in passing that the bureaucratic system in India is essentially of the Weberian model. The question of innovation in the Department of Family Planning is related to the larger question of innovation in the bureaucratic system as a whole. The controversy as to whether the Weberian model can cope with development programmes continues. It is generally felt that the model is more operational in a *laissez faire* system and is more prone to maintaining the *status quo* rather than introduction of innovation. The principles on which the system functions are not particularly geared to bring about social change. It is difficult for a sub-system (Family Planning Department) to introduce changes within itself without reference to the total system. Nevertheless, some efforts have been made. The set-up of a technical wing within the department is one such. The hiring of a marketing expert on a contract basis outside the ranks of the administration to help market the contraceptives is another example. The communication system, the organisation of mass camps, the introduction of the intensive district scheme, the setting up of a feedback system, are indicative of the efforts to attain higher levels of performance through changes. However, these changes operate within the constraints of overall

bureaucratic system. There has been some discussion as to whether the programme can be handled better by voluntary organisations. No voluntary organisation is in a position to take up the programme of the magnitude that is being carried on at present. One possibility might be that a particular region might be allocated to a voluntary organisation. It can be tried out on an experimental basis in one or two areas. The idea of setting up a separate organisation (Corporation) has also been floated. To set up an organisation which can handle a national programme is rather complicated. The programme run by the Government has a different status and is more readily accepted. However, there is also the disadvantage of the difficulties in introducing innovative management techniques.

CHAPTER 7

Training and Research

TRAINING

The training of the personnel in the family planning programme is in itself a job of substantial magnitude. There are a large number of training centres which have been established to train the personnel of various categories in the programme.

There are 7 Central Training Institutes, 44 Regional Training Centres, 321 Centres for Training of Auxiliary Nurse and Midwives (some of them are run by voluntary organisations with a 100 per cent grant) and 23 Lady Health Visitors Training Centres. Apart from these there are 16 Central Family Planning Field Units which also impart training to the workers. The Central Institutes training the faculty of the Regional Family Planning Centres. They also provide technical guidance to them. They also undertake research in various aspects of the programme. The International Institute for population studies (Bombay) has two teaching programmes, *viz.*, certificate in population studies and diploma in population studies. Students from the E.C.A.F.E. region are also enrolled in these courses.

The training for the A.N.Ms. and the Lady Health visitors is of two years duration. The orientation courses which are organised both by the Centre as well as regional institutions range from a week's duration to three months. The field units train the A.N.Ms, Health Visitors and other peripheral workers of the department of Health as well in the family planning work. The training centres' capacity seems to be well utilised. Over 25,000 persons were trained by the regional family planning training centres and field units during 1972-73. (The Government proposes to close down any regional training centre whose

utilisation of the capacity is less than 60 per cent). There are variations with regard to the staff in position of the various centres—from 45 per cent to 90 per cent. In majority of the cases the staff at the training centres have the requisite or higher qualifications. A variety of courses have been developed to suit the needs of the different categories of workers. The course contents are evolved in workshops usually arranged by the National Institute of Family Planning.

There is some discomfort in the training Institutes as the period of training is short for most categories of workers. There has had to be a compromise on this. There are over 150,000 workers that have to be trained. The decisions was to train as many as possible with a rudiments of the programme and put them in the field. The other problem is that the impact of the training is reduced as there is substantial mobility of the doctors at the primary health centres who holds a crucial position in the programme.

RESEARCH

The need for research was recognised early in the programme not only in the bio-medical area but also in the inter-relationship of demographic, social and economic fields. There are 8 demographic research centres, 4 communication action research centres. Apart from this, universities have also been financed by the Ministry to undertake research studies. The demographic centres are usually located in universities. An expert Committee is appointed by the Government from time to time which coordinates and promotes research. Over 500 research studies have been conducted by institutions so far (200 sterilisation, 150 in I.U.D.C., 200 in knowledge, attitude and practice). More specifically the subjects studied are demographic and socio-economic characteristics of contraceptors, mass vasectomy camps, variation in family planning performance between States, process and pattern of decision making, factors, influencing family size, norms, response of the local leadership to the programme, etc. These studies can be classified under three headings identified by the Committee : (*a*) Diagnostic, (*b*) Action Programmes; and (*c*) Statistical assessment of

seems to have had negligible effect on policy formulation and administration. In the Department of Family Planning the feeling expressed was that the research studies have not provided much information of value, in policy formulation or the improvement of the implementation system. The research centres on the other hand held that the administration was not interested in their findings. The problems thus are at both the ends, *i.e.*, with the researchers as well as the programme planners. The U.N. Mission had said that the research would be meaningful only when carried out in an administrative and organisation framework wherein the priorities of research are determined and the findings are channelised into action programmes. The set-up at present does not quite fit such a model.

The problems seem to arise essentially because of this. The studies conducted may have no direct relevance to policy formulation or implemention. Often the researchers are not able to translate their findings into language which is understandable to the administrators. The involvement of the social scientists in applied programmes is rather recent and very limited. There is little training available in the universities for undertaking applied studies. To add to this overall problems there are more specific once with regard to demographic centres which restricts their contribution. K.C. Seal lists among others the following :

1. Inadequate staff at the Centres (training centres visited did complain of this).
2. The studies conducted are micro-level.
3. Studies are often conducted in a hurry and devoted a particular objective without considering its related aspects.
4. There have been only a few studies which have direct policy implications.
5. Analysis in depth is lacking in most studies. The "Why's" of behaviour are rarely gone into. (This may be due to inadequate staff or time).
6. There is lack of communication between the research centres themselves.
7. There is no uniformity in the concepts used, making comparisons difficult.

their problems. They do not formulate their questions in 'reasonable terms'. They are unable to appreciate the aspiration of the research workers to produce studies of scientific quality (K.G. Rao).

The problems stated above suggest the need for a much greater interaction between the researchers and the policy planners. They must learn to appreciate each others problem as well as to communicate in a meaningful way. The researcher must make a greater effort to respond to the practical problems of the family planning programme so as to have some impact on policy formulation. Their urge to be very scientific or systematic has to be suppressed to provide practical answers. If the administrators can formulate their questions in specific terms the process can be expedited.

The universities and other research institutions have not taken up many studies in the area of family planning. Recently two experimental projects have been started in two States (Karnataka and U.P.) by the World Bank. Two management institutions are acting as consultants to these projects. Effort is needed to get greater involvement of universities and other research institutions.

CHAPTER 8

Summary and Conclusions

BEYOND MANAGEMENT

The Indian programme has been in operation for about 25 years, although an all out effort was made only about ten years ago. Given the various aspects of the programme (infrastructure, resources, specific goals, etc.) it should have had a high level of accomplishment. The number of couples protected is 15 per cent as against a contemplated 30 per cent and the birth rate has come down only by 4 points in the last five years. What are the factors that might explain this?

Mention has already been made about the feeling regarding the relationship between total development and population growth. There is some evidence that the States which are more developed have a higher rate of performance. The question is with regard to the criteria of development. Some items (urbanisation, rate of literacy, income per capita, etc.) were examined and it was not possible to establish clear correlations between them and population growth (see Table II). The level of development could be one factor. Implicit in this argument is the view that if there is development, the problem of population will take care of itself. This could even be an escapist approach. The need to work for total development cannot be overstated but this should not prevent continued frontal attacks on population control. The two are not an either or proposition.

The political support in India for the programme has been rather halting. None of the political party manifestos* make a reference to the population problem. In one State the officials said that it was almost impossible to get a Minister to talk about family planning from the platform. While in an other there was no difficulty. Many have emphasised the need for a forthright

* 1971 Elections

political commitment. Some political parties (Jan Sangh, Communist) are opposed to the programme which makes it difficult for other parties to come out openly for the programme. It is a sensitive area as there are religious and political overtones. The unambiguous support of the political leaders could make a change in the attitudes of the people. One State pointed out that it had two seats less in the Parliament because of reduction in the population.

Social attitudes are not favourable to family planning. The status of women in rural areas is dependent on the number of children, particularly sons, she has. The desire for old age security makes them have more children so that there is an assurance of the survival of at least some of them. The control of birth of children is a personal matter. The relationship between personal welfare and national welfare is not easily conceived. The programmes tend to make personal welfare an end in itself. The message of personal good being a part of social good has yet to get across.

The strategy in a programme is dependent on the technology available. A search is on for a cheap, dependable, easily administered and reversible method of birth control. At present the only dependable method is sterilisation, which is not reversible. (It is now claimed that vasectomy is reversible). The I.U.C.D., the Pills have had bad reactions. The condoms are not entirely dependable. A technological breakthrough might even provide a short cut to the total development approach.

STRENGTHS AND WEAKNESSES

In summary, the following are the strong points of the programmes. It is a national programme with a vast infrastructure for the implementation of the programme. There are a large number of training institutions established to train the personnel. The role of research-bio-medical, demographic and socio-economic is recognised and funds are made available for conducting studies. There is a wide network for mass education. Supplies of contraceptives have been adequate. The organised sector and voluntary organisations have been involved. Provision has been made for feedback through the evaluation and intelli-

have been stated in specific and measureable terms. Although the programme operates by itself, its relation to other aspects is recognised. On the whole, accomplishments are commendable.

The major problem has been of getting qualified personnel. Only a little more than half the required staff is in position at the rural level. Apart from this there is mobility. The involvement of the States is minimal. They do not seem to have any stake as the programmes are centrally sponsored and funded. The targets are set in a rather mechanical manner. The follow up of the cases (particularly I.U.C.D. and mass vasectomy campaigns) has been poor. The mass media have not got across the full message of the programme to the public. The programme continues to operate in isolation and has not involved the general administration (*e.g.* District Collector) very much. Sufficient use of research institutions is not being made to get a comprehensive feedback. There is no clear political commitment to the programme.

The different levels of performance in the States could probably be explained by analysing the strengths and weaknesses in each of the States. The programme in Tamil Nadu started in 1956. There was concentration on sterilisation (vasectomy) from the beginning. There is a clear political commitment to the programme. The State spent Rs. 10 million from its own budget, particularly for giving higher incentives to the clientele. The personnel are recruited on the State cadre and the term of their appointment is indeterminate.

The role of the extension educator has come in for much discussions. The need for motivating the people is accepted. Both in Tamil Nadu and U.P. the feeling is that they have not been able to build rapport with the community. Most of the extension workers are trained social scientists. Unfortunately, at times, the appointments have been political. In Tamil Nadu the officials were of the view that A.N.Ms. and L.H.Vs. were better motivators as they could respond to many health needs of the individuals. One State has abolished the post.

Policy is essentially decided by the Centre. The States feel that there is need for greater participation. The Centre feels all the necessary opportunities are provided for them to convey the idea through various channels. The Centre also feels that it is the only way the programme will work as no State would take

initiative on its own to start the programme. The more advanced States might work the programme on their own, but this would create problems on a national level. If the programme is supported by the Centre, then all the States will have to be allocated funds.

AREAS FOR INVESTIGATION

A few suggestions about the area which might be looked into further are being mentioned. There has been some attempt to get the cooperation of the private practitioners, to spread the message of family planning in the rural areas. Over two-thirds of the rural people go to the indigenous medical practitioners. Their help could be sought to motivate the people to limit the size of the family. The traditional village midwife can also help though she has been rather reluctant—efforts must continue to get her cooperation.

About 60 per cent of the population is below 25 years of age. The age groups concentrated on, so far are higher. The younger age group need to be educated as early as possible. The educational institutions should be brought into the programme more prominently. In the rural areas, through the workers in the community development programme (both male and female) and the panchayat leaders, the lower age groups should be contacted.

A pre-counselling programme should be introduced. The training programme for the personnel should include sessions on pre-counselling. Volunteers for sterilisation, I.U.C.D. or abortion should be informed of the processes and also the possible after-effects. They should be told what action to take for specific reactions. This could help in creating greater confidence and for a better follow up.

There is substantial difference in the performance of the different areas. Some hypothesis have been suggested by various people as to the causes. Studies in depth must be conducted which would throw light on the causes for differential performance. Research studies on motivation among workers, the administrative system, the impact of training, are wanting. Providing tenure to the workers would mean better motivation.

rather of ten years' duration. The training of the workers should be broad-based so that they could be absorbed in other health programmes with some orientation if need be. The multi-purpose approach might provide a solution.

The programme for controlling the population is a long-standing one. Substantial progress has been made—the most important of which is the creation of an infrastructure reaching the remote areas of the country. The progress has not been as rapid as planned. There is a real concern regarding this. There also seems to be a sense of helplessness in the Department. Some States have even suggested compulsory sterilisation after specific number of children. The Health Minister in a recent speech said that at present it was not necessary to consider such a proposal. There is dynamism in the programme as various schemes are being tried. It is not beyond the scope of the organisation to achieve the targets set.

The Post Script

The manuscript was got ready for publication in 1974-75. There are some changes in the situation since then.

A National Population Policy was laid down by the Ministry of Health and Family Planning in a statement to the Parliament in April, 1976 by the Minister of Health and Family Planning.* In the statement the question of the relation between development and population growth was considered. There can be no categorical assertions on this aspect. The statement says: "Indisputably, we are facing a population explosion of crisis dimension which has largely diluted the fruits of the remarkable economic progress that we have made over the last two decades." It also makes the point: "Our real enemy is poverty . ." The statement indicated a clear commitment to the family planning programme and went on to say: "The time factor is so pressing, and the population growth so formidable that we have to get out of the vicious circles through a direct assault upon this problem as a national commitment." The political support for the policy was also implicit. "The President in his address to the joint session of the Parliament reiterated the importance of stepping up family planning efforts, and the Prime Minister has on several occasions laid stress upon the crucial role that few control has to play in the movement towards economic independence and social transformation ..."

The target now set is to reduce the rate of population growth to 1.4 per cent by 1984. The age of marriage is proposed to be raised to 18 years for girls and 21 for boys. The representation to the Lok Sabha and the State Assemblies will

*See Appendix I, pp. 79-85.

be on the basis of 1971 census till the year 2001. (Representation is based on population and some states were afraid of losing some representation if the population decreased). Special efforts are to be made for female education. The monetary compensation were raised. The statement also stressed the need of peoples' participation.

Achievements

The analysis of achievements is based on the statistics of 1972-73 which was the latest available then. The statistics for 1974-75 have now become available (Family Welfare Planning in India Year Book 1974-75).

The table below gives the comparative figures for 1972-73 and 1974-75.

STATISTICS OF SOME ASPECTS OF FAMILY PLANNING PROGRAMME FOR 1972-73 AND 1974-76

		1972-73	*1974-75*
Percentage of couples protected		15.0	16.3
Birth rate		37	34.6 (1973-74)
Death rate		16.9	15.5 (1973-74)
Per cent Achievements to targets set	Sterilization	54.8	67.5
	IUD	37.4	71.7
	C.C.	56.3	71.9 (Figures are provisional)
MTP		44147	96856
Staff in position	State in	66.1	66.5
	Dist.	78.3	80.9
	Urban	64.6	62.1
	Rural	56.5	75.1

(SOURCE : Year Book, Department of Family Planning)

The data for 1974-75 shows an improvement in performance but there is still a long way to go. If the target of reducing growth rate to 1.4 is to be reached, about 40 per cent of the

eligible couples have to be protected. As of present only 16 per cent are protected. The population in India in 1976-77 is estimated to be around 625 million. If the estimate is correct then it would seem that the growth rate has not diminished in spite of the birth rates having dropped. Part of the explanation is that there is a drop in the death rate also.

The need to control population growth is now generally accepted. Various measures are being added all the time to the programme. The ultimate objective is to provide for a better quality of life for the people of the country. Family Planning and Welfare Programme is one aspect of the programme designed to achieve that goal.

Family Planning Programme in Government Organizations

INTRODUCTION

In a seminar held in Bangalore in July 1976, the participants agreed that there was ample justification for special attention to the organized sector on account of its strategic and favourable situation. The population in the organized sector in India is estimated to be about 19 million. These are mostly target couples* or on the verge of marriage. In addition, the vast majority belong to the younger age group and so the impact on fertility will be high if the family planning programmes are successful in the sector. The other important points are, the better socio-economic conditions of the workers, leading to better acceptance of family planning, the rural link of the industrial workers for propagation of the small family norm, better facilities for implemention and evolution of the programme in the organized sector and finally the cooperation and enthusiasm for this programme of many employers as also of the trade unions and other voluntary agencies. These factors have to be taken into consideration when an assessment of the family planning programme is made in the government organizations such as the Ministry of Defence, Railways, Posts and Telegraphs and Labour. The performance naturally would be expected to be at a higher level than for the total population of the country.

*The Family Planning Department estimates that 60 per cent of this population are eligible couples. ILO estimate is 80 per cent. Of the total eligible couples in India the organized sector would thus have around 15 to 20 per cent of them.

It is estimated that the addition of the labour force during 1971-86 will be around 78 million which is about four times the present size of the employment in the organized sector. Excess of population will adversely affect the quality of the labour force and level of employment, production and productivity and labour welfare. These factors also need to be taken into account in analysing the family planning programme in these organizations.

The present paper looks at the programme in the Ministries of Railways, Defence, Labour and Posts & Telegraphs. At the outset it may be said that the programme in the Ministry of Labour and Posts and Telegraphs is limited. Reference is made to the programme for government employees also.

In the Defence and in the Railways there is a wider coverage of the employees of the organization. Each of the programmes will be described separately. Some of the common problems will be analysed later.

MINISTRY OF DEFENCE

In the Ministry of Defence, the scheme for family planning programme was initiated as a welfare activity in 1951. Family Welfare Centres were established in military units, supported and financed out of the unit funds.

In 1966 when the Ministry of Health and Family Planning launched the family planning programme in earnest and the armed forces fully participated in the programme.

The Organization

The Family Planning set up in the armed forces consists of three main components, namely, the supervisory echelons at the various levels, the Family Welfare Planning Centres and the Armed Forces Hospitals and Station Health Organizations. The functional organizations are the family planning welfare centres and the medical institutions.

There are 134 Family Welfare Planning Centres under the administrative control of the three services and the Directorate General of Ordnance Factories. The distribution of these centres is given in Table I.

TABLE I

DISTRIBUTION OF FWPCs

HQ Formation	*Class I*	*Class II*	*Total*
HQ	27	47	74
Naval HQ	4	7	11
AIR HQ	8	27	35
DGOF	5	9	14
Total	44	90	134

Class I Centres are established in stations with a population of over 50,000 and Class II Centres in smaller stations. The pattern of staffing for the two types varies. The pattern is given below :

Class I		*Class II*	
Lady Medical Officer ...	1	Lady Medical Officer (part time)	... 1
Family Planning Extension Educator	1	FPEE	... 1
LHV	... 1	LHV	... 1
Clerk-cum-Storekeeper	... 1	Attendant	... 1
Sweeper (part time)	... 1		

The hospitals and the Station Health Organization combine together to render the jawans and their families integrated and comprehensive health care covering all aspects of preventive and restorative services. Family planning education, advice and services constitute an integral part of the health care programme. MTP facilities are now available in all service hospitals. These services are free to the Armed forces personnel and their families and to the vast civilian population residing in

the military cantonment areas and other military stations. Civilians who are not entitled to this service are admitted to the military hospitals for sterilization and IUDs and the hospital expenses are paid out of the grant from the Ministry of Health and Family Planning.

All expenditure on the family planning set-up of the armed forces is borne by the Ministry of Health and Family Planning. The total grant is Rs. 38 lakhs.

Demographic Characteristics

In evolving the strategy for implementing the national programme, as in any group, the armed forces have taken note of the demographic and other characteristics of the group. More than 95 per cent of the population in the defence services is in the age group of 18-35 years. A recent study has shown that the average age of the soldier is 29 years and that of his wife 23.6 years.

Family accommodation is not available for the bulk of the troops. A vast number do not live with their families because of limited availability of married accommodation in the posting stations. It may be mentioned here that as an indirect incentive, those who have only two children are given preference in the allocation of quarters. Free railway passes, admission to Sainik Schools, and free shows are the other ways for inducing the soldiers to accept family planning.

The personnel in the armed forces are trained to discipline themselves physically and mentally and to keep themselves and their family healthy. There is ready acceptance of the health promytional measures including the message of family planning.

The percentage of literacy among the soldiers, sailors, and airmen is much higher than in the general population. Moreover continuing general education is a feature of military life.

Family Planning Measures

(*a*) *Family Planning Education* : The foundation of the programme of health and family planning is based on the education of the jawan for the welfare of his own family during service and on retirement. Family planning education is included in the regular training

programmes of the armed forces personnel, including the officers from the recruitment stage onwards. A suitable curriculum is drawn up in consultation with the Family Planning Departments. Posters, films, models are used in the process of education.

(*b*) *Spacing*: Spacing is the second most important measure recommended to the jawan and for this purpose Nirodh is extremely popular. This is freely issued to the jawan. IUD and other conventional contraceptives are also encouraged for adoption by army wives.

(*c*) *Sterilization :* Sterilization is offered to the jawan with more than two children including one male child. Where the wife is more agreeable for sterilization proper arrangements exist for tubectomy in the hospitals. Facilities are made available to all the soldiers even in the forward areas. All the armed forces hospitals can undertake termination of pregnancy. Regular facilities are available in these hospitals for cases of delayed periods of termination and suspected pregnancies.

Post partum programme has been authorised in the selected medical institutions in the country. The progromme is carried out in the medical college at Poona.

The family planning activities have been amalgamated with maternal and child health care. Proper medical and health facilities for mothers and children, including comprehensive immunization, ante-natal/post-natal care are, being provided by the FWP centres. There is also distribution of folic acid and ferrous sulphate tablets for safeguarding the health of expectant and nursing mothers.

Achievements

Table II gives the achievement of the family planning programme among the armed forces from 1967 to July 1976.

It may be noted that there is overall continuous increase in acceptance of all the three programmes—sterilization, IUD insertions and use of conventional contraceptives. It is not possible to indicate as to what percentage of the population is covered, as the total population of the armed forces is not available. Two studies have been conducted which show that there has

TABLE II

NUMBER OF STERILIZATION/IUD INSERTIONS/USERS OF CONVENTIONAL CONTRACEPTIVES (C.C.) IN THE ARMED FORCES 1976

Year	*Sterilization*	*IUD Insertions*	*Users of C.C.*
1967-68	5520	5417	6471
1968-69	5720	3696	12715
1969-70	6332	3580	24360
1970-71	7342	3489	30376
1971-72	7690	3885	30034
1972-73	10364	3752	35760
1973-74	9938	3952	41375
1974-75	11391	4689	47102
1975-76	14843	4715	54365
1976-77 (upto Jan. 77)	25377	3635	55810
Total	104524	40810	337368

been an impact of the family planning programme among the armed forces. In one of the studies it was found that 93 per cent of the live births occurring in one year among the families of the service personnel were of 1-3 order. Only 7 per cent accounted for fourth and higher birth orders (All India figures is 47.0 per cent as per SRS, 1972). The average number of children in completed families (age of wife 40 to 44 years) was found to be 4.4 as compared to the All India figures of 5.5. The second study revealed that the incidence of improvident maternity among service personnel had declined from 24.4 per cent in 1960-61 to 16.4 per cent in 1970-71. Over the decade, the mean age of mothers at first child birth had risen to 22.6 years in 1970-71 from 21.5 years in 1960-61.

THE RAILWAYS

The Indian Railways have been implementing the family

welfare planning programmes in their jurisdiction since 1965. These centres have now become a part and parcel of the health services. These services are catered mainly through 62 family planning centres and 29 sub-centres established throughout the Railways.

The maternity child welfare programme has been integrated with the family planning programme. Timely immunization of expectant mothers against diptheria, whooping-cough, etc., have been intensified.

Education

The main strategy of implementation is directed to stress the importance and benefits of an ideal and happy family life and explaining, in simple and direct terms in local language, the ways and means of achieving it. Inter-personal communication through family planning staff is made for motivation of the eligible couples. Suitable orientation is given to different categories—supervisory staff, leaders, voluntary personnel and others. Specialised training for the DMO is also provided.

The strategy of approach is based on the marital status of the employee. Sex education is provided to persons about to be married. The newly married couples are advised postponement of the first child by at least 3 to 4 years using one of the contraceptives. When the first child is born all immunizing facilities are given and the couples are advised to accept the IUD conventional contraceptives so as to get the second child after 3 or 4 years. When the second child is 4 or 5 years, the couple is advised to accept one of the permanent methods. The means of communication are films, posters, standardised lectures. Films strips have been developed to go along with standardised lectures.

Achievements

According to the records, since its inception in 1965 to August 1976, 33.24 per thousand population have been covered by sterilization, 9.07 by IUD and 28.98 by conventional contraceptive methods, *i.e.*, a total of 71.29 per thousand population have been covered by one or the other methods. The details of the achievements in the years 1973 to 1976 are given in Table III.

TABLE III

TARGETS AND ACHIEVEMENTS AND PERCENTAGE THEREOF FOR THE YEARS 1973-76

	1973-74		*1974-75*		*1975-76 (up to July)*	
Sterilization						
Target	10500		7300		13200	
Achievement	11715	(110)	11358	(156)	27404	(208)
IUD						
Target	6400		4600		3400	
Achievement	3101	(49)	3177	(69)	4593	(135)
C.C. Users						
Target	114500		60000		180000	
Achievement	139167	(122)	161160	(267)	207779	(115)
Total						
Target	131400		71900		196600	
Achievement	153984	(117)	175695	(244)	239779	(122)

Note : Figures in brackets are percentages.

It would be seen from the above table that the achievements in all the three years has been more than the target set. However, in the first two years, the achievement with regard to IUD is less than the target set. There is also a wide variation in the performance of the different zonal railways. While the overall achievement in the Western Railways was about 245 per cent, it was only 79 per cent in the North-Eastern Railways. In 1974-75 the achievement in South Central Railways was 524 per cent and in the Western Railways 450 per cent whereas it was 130 per cent in the Eastern and 146 per cent in the Central Railways. Compared to 1974-75 the achievements in 1975-76 are about half as much in terms of percentage. It may be noted that the target set for 1975-76 was more than 2½ times the target set in 1974-75.

In 1976-77 a large number of mini-camps are being organized for sterilization and IUD insertions. The IUD targets have been over-reached in 1975-76. It is difficult to explain, as why this has happened. May be better follow-up. These camps are centred around health centres and usually they cover about 40 sq. miles. These are also organized in the railways hospitals The highest number of operations performed in one

on which a good follow-up can be maintained. The incentives given to those undergoing the operations are allocated by the Department of Family Planning. During the Railway Week Award, some recognition is given to good performance in the family planning programme.

The Characteristics of the Population

The number of employees in the Railways as of March 1975 was 14,34,225. Out of this, the number of eligible couples (in the age group of 14 to 44 years) is 11,82,889 about 83 per cent of the total.

Of the eligible couples, more than half have three children. About 10 per cent have no children; 17 per cent have one child and 22 per cent have two children. Of the eligible couples 43 per cent have been covered by one or the other methods. Details are given in the Table IV.

TABLE IV

UPTO DEC' 1976

		Percentage covered to Total eligible couples
(*a*) Sterilization	2,23,446	20.1
(*b*) IUD	13,529	5.5
(*c*) C.C. users	1,99,685	17.6
Total	4,36,660	43.2

The Organization

The Deputy Director for Planning, Railway Board, is responsible to the Additional Member, Health Railway Board. Under him, there is an administrative division, publicity officers and health education officers. At the zonal level, there is the Senior Medical Officer for Family Planning, Statistical Assistants, an Extension Educator and a Projectionist. At the unit level, there is a Medical Officer, Extension Educator and Lady Health

Visitor. There are male and female field workers. There is a Computer Clerk and Upper Division Clerk and an Attendant.

The Computer Clerk is expected to send information regarding achievements by the 8th of each month to the District Medical Officer, Family Planning. The information is expected to reach the Zonal Officer by the 7th of the following month and the headquarters by the 15th of the same month. The headquarters sends on the information to the Ministry of Health by 20th of the same month. A target couple Register is maintained at the unit level. An effort is made to cover as many as possible.

The total budget for the personnel and programme is a grant from the Department of Family Planning. Rs 62 lakhs are made available to the Railways annually.

Studies

A birth rate study was conducted in 1970 which reflected the rate of birth had come down from 34 3 in 1961 per thousand to 29.1 per thousand in 1969. Another study is being conducted at present on the birth rate. Also KAP studies are being made at present.

The trade unions have neither been very responsive nor are they against the programme. Efforts are being made to get active cooperation from them. The leaders of the trade unions are being given the necessary orientation. They are also being involved as members in the implementation committees at the zonal level.

As the Railway quarters are compact, mahila samitis have been organised which, apart from other activities, are also helping in the family planning programme.

THE COAL MINES

The family planning programme has been undertaken in the organization from 1957 onward. The organization has a Family Planning Officer to control and supervise the entire programme. The programme has been intensified since 1966-67. There are 11 centres—two central hospitals and nine regional hospitals. Specially trained field staff is doing extensive propaganda work amongst the mining population. Five static and 3 mobile units are also functioning

different coal fields. The achievements of the various programmes are given below :

TABLE V

	No. of Nirodhs distributed	*IUD*	*No. of persons using C.C.*	*Sterilization*
1973-74	2,10,390	10	38,342	833
1974-75	1,61,438	35	30,178	1317
1975-76 (Provisional)	2,25,000	200	35,000	N.A.

Charts, films strips, cinema shows, dramas, supply of literatures are the ways and means used in communicating the message of the family planning programme among the workers.

The expenditure during the year 1971-76 is as follows :

	Rs.	
1973-74	2,65,000	
1974-75	3,04,220	
1975-76	4,30,000	(excluding ILO project)

The budget* is born by the Department of the Family Planning from their own resources. From the help received from ILO/UNFPA, the family planning programme has extended to other mines, namely, mica, iron ore, limestone. A Medical Commissioner has been appointed to supervise the work. The total number of workers in all the mines is about 1 million. The total population is about 4 million. The achievements have to be viewed against these numbers. No information regarding the characteristics of the population is available. While in the coal mines salaries are fairly adequate, in the other mines salaries are very low. (In the mica mines extra incentives are given from thier own welfare fund). The programme emphasises

* The total grant from the Department of Family Planning is Rs. 25 lakhs. The grants cover the ESIC, mining areas, trade unions and seminars.

vasectomy as no women are allowed under the mines. There are no qualified persons to perform the tubectomy operations.

There are six special projects run with the help of the UNFPA through the ILO and the Ministry of Labour. The schemes are:

(1) *Augmentation of the employees state insurance scheme.* The components of this project are:

(*a*) Provision of sterilisation beds in 65 centres.

(*b*) Employment of full-time Motivational Education Workers in each centre working through the dispensaries, clinics and hospitals. Thirty-one of the 50 full-time Educators are in position. The programme started in June, 1976. While there are areas that need to be investigated, the progress seems to be satisfactory with regard to the target set, of 3500 sterilizations.

(2) *Strengthening of the family planning programme in mining areas.* The project has not yet got off the ground as the Project Director has not been appointed yet.

(3) *Appointment of Family Welfare Officers and giving population education for regional trade union officers.* The programme started in October1976. "The project is designed to enlist the trade union organizations directly in the national family planning programme, through such activities as national seminars, workshops, appointment of full-time Family Welfare Officers and core of voluntary motivators."

(4) *Similar programme for Hind Mazdoor Sabha.* The formal communication from the Government on this project is still awaited.

(5) *Regional labour management seminars for population education in the organised sector.* Four seminars are planned, the purpose of which is to promote the government population policy. Also a national seminar on the Role of Labour Administration is organised.

(6) *Population education in the organised sector.* The project is designed to develop the expertise and capacity of the Central Board of Workers Education to set up a small population education unit and to prepare material for incorporating population education as an integral part of the workers' education at all levels. The assessment is that the project is proceeding well,

THE POSTS AND TELEGRAPHS DEPARTMENT

The Posts and Telegraphs Department has 12 out-patient dispensaries. All of these have been provided with a Family Planning Extension Educator and family planning field workers with the funds from the Department of Family Planning. (The grant has recently gone up from Rs. 75,000 to Rs. 1,50,000). There are no facilities for vasectomy and tubectomy in these dispensaries nor for IUD insertions. When the employees in the Department are motivated, they have to go to the district hospitals for the services. Some of the post-offices stock Nirodhs and sell them. There is a depot-holder scheme. At the head-quarters also there is no special officer who is dealing with the family planning programme.*

GOVERNMENT EMPLOYEES

The number of employees in the Government is very large, the population characteristics of whom are somewhat similar to the organisations that have been described. They are also a captive audience. The effort is to reach this group through the Central Government Health Service. Each of the CGHS centres has a Family Planning Officer, and also an Extension Education Officer. The norm of the small family is being propagated through a number of disincentives. Those who have more than 3 children are given low priority in the allocation of houses. Leave travel concessions and medical benefits are denied to the fourth child and after. Persons with more than 3 children would also have difficulty in getting employment in the government. In fact, having a fourth child is considered violation of the conduct rules. These measures, it is expected, will have substantial bearing on controlling size of the family among the government employees.

In the educational system, the teachers are being actively associated in the programme. The scheme for population education is being implemented. The Primary Teachers Federation is involved in the family planning education programme. Where PTAs exist, efforts are being made to get their cooperation.

It is not possible to make an assessment of the programme

* Four posts were sanctioned recently.

in this area as there is no information. Some spot studies could provide some idea of the situation.

GENERAL PROBLEMS

In the implementation of a programme there are many factors which can affect the performance The performance, as seen from the statistics given above, shows that the Railways, the Defence and the Mines are doing fairly well. However, it has to be measured not against the overall target for the general population as the population in this organised sector is a "captive audience". The data available at present is not sufficient to draw any conclusion from that point of view. The indications seem to be that there is greater acceptance of the programme in these organisations as compared to the overall population. It must also be noted that the socio-economic conditions of this group is better.

The policy for the family planning programme is formulated by the Family Planning Department. Only the Railways have a representative on the Central Committee. There has been no effort by any of the organizations mentioned to develop a policy of its own. It may, however, be stated here that the Defence is considering seriously the possibility of making sterilization compulsory after the second child. There is a feeling that the policies laid down are not often clear. Also, there seems to be several changes in policy which are not communicated clearly to these organizations. The implementing agencies, therefore, feel that there is need for clearly laid-down policy and an analysis of the implications for implementation. It is interesting to note that none of these Ministries have allocated any funds from their own to the family planning programme. There were complaints about the inadequacy about the grant. There seems to be little inclination to supplement the grant from their own funds. A feeling was also indicated that the grants from the Department of Family Planning were schematic which made it difficult for these organizations to deviate from the set pattern. The Department of Family Planning, on the other hand, feels that its resources are limited and there is plenty of scope for the organizations concerned to allocate funds from their own budgets.

The staff position is problematic. All the organizations complained about not having all the staff in position. The reasons given were, low salaries, lack of tenure and the fact that they may be posted to remote parts of the country. The data with regard to the staff position in the Defence Service is given below:

STAFF POSITION

Staff position	*Post sanctioned*		*Staff in position*
Establishment at supervisory echelons	(*a*) Medical Officer (FP)	4	2
	(*b*) Statistical Assistant	9	4
	(c) Lower Division Clerk	11	11
Establishment at FWP Centres (Class I & II)	(*d*) Whole time lady Medical Officer	44	27
	(*e*) Part time Lady Medical Officer	90	46
	(*f*) Lady Health Visitor	134	106
	(*g*) Family Planning Extension Educator	134	104
	(*h*) Store keeper-cum-clerk	44	36
	(*i*) Attendant	134	117
	(*j*) Part time Sweeper	134	46

The situation is similar in the Railways and the Coal

Mines. Greater incentives in terms of salaries, allowances and facilities may have to be given to attract the staff.

The training of the staff members also needs to be considered. It is felt that the training given in the regional training institutions does not take into consideration the specific population which these organisations deal with. In fact the Railways do not send their personnel for training to these institutions. They prefer to have a training institution of their own for their workers. The Ministry has not looked upon the suggestion with favour.

Another problem that these organizations face with regard to the staff is evaluation of their performance. There are no clear guidelines from the Ministry regarding the criteria on evaluation of the performance of the staff members. Except in the Railways which have developed a seven-star* system for evaluating the workers, none of the others have developed one. This is another area in which a great deal of attention needs to be given. In view of the fact that the situation differs from place to place and from organisation to organisation, serious thought has to be given for assessing the workers' performance.

As has been mentioned earlier some research studies have been made in the Railways and the Defence. However, this was some time ago and does not deal directly with the problems of implementation, information system, etc. Here again it was felt that there were not sufficient guidance and help from the Department. There was even a complaint when the study was conducted by the National Institute of Family Planning that the report had not reached the concerned organizations even after about five years or so. None of the organizations has facilities or resources for conducting the studies by themselves. The role of the National Institute for Family Planning and regional institutions and demographic centres needs to be considered in this respect Some of the organizations are keen on research studies being conducted which would give information in regard to their attitudes and the level of acceptance of programmes for their own population. The Department feels that a reliable information system needs to be developed. While it is conceded that occasional studies are helpful, the regular flow

* See Pages 74-75.

of valid and reliable information is more relevant for policy decisions.

Help from the UN organizations might be sought in undertaking studies of the programmes in the organised sector through universities, research and management institutions (*e.g.*, Staff College, IIPA, IIM, NICD, etc.)

None of the organizations had information about the rate of infant mortality within their own population. It has been suggested that for the general population, the high rate of infant mortality has a bearing on acceptance or non-acceptance of the programme.

Given the specific groups, special programmes in population education follow-up could be undertaken. Means have to be developed to intensify the programme through greater propaganda/education, etc Some of them are doing this but there is scope for further intensification. The defence services can take up the programme in the ordnance factories. The programme there is not as intensive as it should be. The Department also feels that the Ministry of Defence could play a more vital role in carrynig the programme to the civil population in the cantonements.

The Posts & Telegraphs Department has serious limitations in view of the fact that none of their dispensaries is equipped for sterilization operations. An experiment could be made in two or three dispensaries by adding an operation theatre. The funds could come either from the Ministry itself or from the Department of Family Planning or the UNFPA. There is also scope for increasing facilities in regional hospitals of the mines.

The trade unions seem to have accepted the programme only passively. Efforts are there to get their active cooperation but these need to be increased so that there is greater involvement. The trade union leaders, however, feel that they are not being consulted. There are some indications that they would like to be involved more and invited to the meetings in which family planning programmes are discussed. They would also like to have credit given to them when there is good performance in the family planning programme when they have cooperated.

The performance with regard to the family planning pro-

gramme is improving but the question still is: is this good enough? The question has to be judged against the fact that the majority of the people in this organisation belong to the younger age group, have better socio-economic conditions and better facilities for the implementation in their own hospitals or other health centres. To answer this question, there is need for more information, than is available at present.

ANNEXURES

STAR SYSTEM

What is a star? It is a symbol which has been taken for using in the column No. 10 of the Target Couple Register, so that one can know the status of motivation and acceptance of family planning methods by the couples. The following progressive symbols have been detailed in the Target Couple Register to use the stars to indicate the seven different stages of persons in accepting family planning practices.

* Contacted: No impression.
** Contacted: Knowledge provided.
*** Using C.C. but irregularly (specify N, Ft, J & D).
**** Using C.C. regularly (specify N, Ft, J & D).
***** Motivated for IUCD or sterilisation (specify I, V or T).
****** IUCD inserted or on regular oral contraceptives (specify).
******* Sterilisation over (V or T) or on oral conventional contraceptives successfully for over 3 years. It can also be issued for couples where wife has had monopause, widow, or widower or a confirmed case of sterility (if not excluded already).

Why star system ?

1. To measure the progress of the programme made by day-to-day efforts. In other words, the progressive score of stars will indicate the concurrent value of the work done by the family planning staff.
2. Increasing score will give the picture of the work at a glance to the programme supervisor.
3. When on visits it quickly tells the worker from where

to start with the couple in the motivational work.

4. It saves the time of the worker while he finds out in the Register the number of couples required to be motivated in the Target Couple Register.
5. It also gives the indication of how much workload still remains to be completed.

How to put star marks

Family Planning staff such as A.M.Os, Extension Educators, Lady Health Visitors, Field Workers (Male and Female) do have target couple register in their possession. When they go to the field to contact employees for motivation, they are to take the help of target couple register. Probably they also supply the list of employees to the other general A.M.Os, voluntary leaders and other for motivational work. The result of the contact by the various workers is to be accounted in column 10 of the target couple register. This result is to be put against each name by putting appropriate star marks given above.

For example

Field workers have visited 10 employees on Monday. Of these, 2 employees have never been contacted earlier. After contact there was no impression in the mind of one employee but the other agreed to accept sterilisation. In this case employee No. 1, where no impression was made, is to be marked with one star, and seven stars in the case who agreed and accepted sterilisation. Particulars of other 8 cases, may be recorded as changes occurred.

Employees No. 3 and 4 were marked with one star before tne visit but now they have come to know about family planning and family planning methods. So mark them with two stars. Likewise go on adding number of stars according to the changes occurred after each visit.

(*From Indian Railways Family Planning Newsletter*)

APPENDICES

APPENDIX I

*NATIONAL POPULATION POLICY**

Statement by

Dr. KARAN SINGH
Former Minister of Health and Family Planning

With 2.4 per cent of the world's land area, India has about 15 per cent of the world's people. It is estimated that our population as on 1st January, 1976 has crossed the 600 million mark, and is now rising at the rate of well over one million per month. Since independence 250 millions have been added, equivalent to the entire population of the Soviet Union with six times the land area of India. The increase every year is now equal to the entire population of Australia which is 2½ times the size of our country. If the present rate of increase continues unchecked our population at the turn of the century may well reach the staggering figure of one billion. Indisputably we are facing a population explosion of crisis dimensions which has largely diluted the fruits of remarkable economic progress that we have made over the last two decades. If the future of the nation is to be secured, and the goal of removing poverty to be attained, the population problem will have to be treated as a top national priority and commitment.

Our real enemy is poverty, and it is as a frontal assault on the citadels of poverty that the Fifth Five Year Plan has included the Minimum Needs Programme. One of its five items is integrated package of health, family planning and nutrition. Far reaching steps have been initiated to reorient the thrust of medical education so as to strengthen the community medicine and rural health aspects, and to restructure the health care

* Statement made in Parliament in April 1976.

delivery system on a three-tier basis going down to the most far-flung rural areas where the majority of our people reside and where child mortality and morbidity are the highest. Similarly, ignorance, illiteracy and superstition have got to be fought and eliminated. In the ultimate analysis it is only when the underlying causes of poverty and disease are eliminated that the nation will be able to move forward to its desired ideals.

Nonetheless it is clear that simply to wait for education and economic development to bring about a drop in fertility is not a practical solution. The very increase in population makes economic development slow and more difficult of achievement. The time factor is so pressing, and the population growth so formidable, that we have to get out of the vicious circle through a direct assault upon this problem as a national commitment. The President in his address to the Joint Session of Parliament this year reiterated the importance of stepping up family planning efforts, and the Prime Minister has on several occasions laid stress upon the crucial role that population control has to play in the movement towards economic independence and social transformation, specially in the light of the 20-Point Economic Programme.

Considerable work has been done in our country in the field of family planning, but clearly only the fringe of the problem has so far been touched. In this context, after a thorough and careful consideration of all the factors involved as well as the expression of a wide spectrum of public opinion, Government have decided on a series of fundamental measures detailed below which, it is hoped, will enable us to achieve the planned target of reducing the birth rate from an estimated 35 per thousand in the beginning of the Fifth Plan to 25 per thousand at the end of the Sixth. Allowing for the steady decline in the death rate that will continue due to the improvement in our medical and public health services and the living standards of our people, this is expected to bring down the growth rate of population in our country to 1.4 per cent by 1984.

Raising the age of marriage will not only have a demonstrable demographic impact, but will also lead to more responsible parenthood and help to safeguard the health of the

mother and the child. It is well known that very early pregnancy leads to higher maternal and infant mortality. Also, if the women of our country are to play their rightful role in its economic, social and intellectual life, the practice of early marriage will have to be severely discouraged. The present law has not been effectively or uniformly enforced. It has, therefore, been decided that the minimum age of marriage should be raised to 18 for girls and 21 for boys, and suitable legislation to this effect will be passed. Offences under this law will be cognizable by an officer not below the rank of a Sub-Divisional Magistrate. The question of making registration of marriages compulsory is under active consideration.

It has been represented by some States that while on the one hand we are urging then to limit their population, those States which do well in this field face reduction of representation in Parliament while those with weak performance in family planning tend to get increasing representation. It is obviously necessary to remedy this situation. It has, therefore, been decided that the representation in the Lok Sabha/and the State Legislatures will be frozen on the basis of the 1971 census until the year 2001. This means in effect that the census counts of 1981 and 1991 will not be considered for purposes of adjustment of Lok Sabha Legislature seats. Necessary constitutional amendment will be brought forward during the current year. Appropriate legislation for other elective bodies will also be undertaken.

In a federal system, the sharing of Central resources with the States is a matter of considerable importance. In all cases where population is a factor, as in the allocation of Central assistance to State Plans, devolution of taxes and duties and grants-in-aid, the population figures of 1971 will continue to be followed till the year 2001. In the matter of Central assistance to State Plans, eight per cent will be specifically earmarked against performance in family planning. The detailed procedures in this regard will be worked out by the Planning Commission.

While there is a direct correlation between illiteracy and fertility, this is particularly marked in the case of girls' education. Wherever female literacy improves, it has been seen that fertility drops almost automatically. It is, therefore,

necessary that special measures to be taken to raise the levels of female education, particularly above the middle level for girls as well as non-formal education plans for young women specially in certain backward States where the family planning performance so far has been unimpressive. The same is true with regard to child nutrition programmes, as high infant mortality and morbidity have a direct impact on fertility. The Ministry of Education is urging upon the State Governments the necessity to give these matters higher priority than has been accorded so far and fully earmarking adequate outlays both for girls education up to middle level and child nutrition.

My Ministry is also in close touch with the Education Ministry with regard to the introduction of population values in the educational system, and the NCERT has already made a beginning in bringing out some text books on these lines. It is essential that the younger generations should grow up with an adequate awareness of the population problem and a realization of their national responsibility in this regard. Indeed, if I may venture to say so, exhortations to plan families are more important for the younger generations than for those who have already made their contribution to our demographic profile.

The adoption of a small family norm is too important a matter to be considered the responsibility of only one Ministry. It is essential that all Ministries and Departments of the Government of India as well as the States should take up as an integral part of their normal programme and budgets the motivation of citizens to adopt responsible reproductive behaviour both in their own as well as the national interest. A directive to this effect is being issued by the Prime Minister to all Ministries of the Government of India, and a letter will also be addressed by her to all Chief Ministers. The performance of family planning in the States will be more carefully and intensively monitored than in the past, and the Union Cabinet will review the situation in depth at least once a year.

Experience over the last 20 years has shown that monetary compensation does have a significant impact upon the acceptance of family planning, particularly among the poorer sections of society. In view of the desirability of limiting the family size to two or three it has been decided that

monterary compensation for sterilization (both male and female) will be raised to Rs. 150 if performed with two living children or less, Rs. 100 if performed with three living children and Rs. 70 if performed with four or more children. These amounts will include the money payable to individual acceptors as well as other charges such as drugs and dressings, etc., and will take effect from 1st May, 1976. Facilities for sterilization and MTP are being increasingly extended to cover rural areas.

In addition to individual compensation, Government is of the view that group incentives should now be introduced in a bold and imaginative manner so as to make family planning a mass movement with greater community involvement. It has, therefore, been decided that suitable group incentives will be introduced for the medical profession, for Zila and Panchayat Samitis, for teachers at various levels, for cooperative societies and for labour in the organized sector through their respective representative national organizations. Details of these group incentives are being worked out in consultation with the concerned organizations.

Despite governmental efforts at Union, State and Municipal level, family planning cannot succeed unless voluntary organizations are drawn into its promotion in an increasing measure, particularly youth and women's organizations. There is already a scheme for aiding voluntary organizations, and it has been decided that this will be expanded. Also, full rebate will be allowed in the income tax assessment for amounts given as donations for family planning purposes to Government, local bodies or any registered voluntary organization approved for this purpose by the Union Ministry of Health.

Research in reproductive biology and contraception is under way in several of our scientific institutions, and there are some very promising developments which, we hope, will lead to a major breakthrough before too long. This is a great challenge to our scientists, and efforts in this direction will receive special attention so that necessary research inputs are ensured on a long range and continuing basis.

The question of compulsory sterilization has been the subject of lively public debate over the last few months. It is

stringent measures for family planning than before. However, the administrative and medical infrastructure in many parts of the country is still not adequate to cope with the vast implications of nationwide compulsory sterilization. We do not, therefore, intend to bring in Central legislation for this purpose, at least for the time being. Some States feel that the facilities available with them are adequate to meet the requirements of compulsory sterilization. We are of the view that where a State legislature, in the exercise of its own powers, decides that the time is ripe and it is necessary to pass legislation for compulsory sterilization, it may do so. Our advice to the States in such cases will be to bring in the limitation after three children, and to make it uniformly applicable to all Indian citizens resident in that State without distinction of caste, creed or community.

Some States have also introduced a series of measures directed towards their employees and other citizens in the matter of preferential allotment of houses, loans, etc., for those who have accepted family planning. In this sphere also we have decided to leave it to each individual State to introduce such measures as they consider necessary and desirable. Employees of the Union Government will be expected to adopt the small family norm and necessary changes will be made in their service/conduct rules to ensure this.

In order to spread the message of family planning throughout the nation, a new multi-media motivational strategy is being evolved which will utilize all the available media channels including the radio, television (specially programmes aimed directly at rural audiences), the press, films, visual displays and also include traditional folk media such as the jatra, puppet shows, folk songs and folk dances. The attempt is to move from the somewhat urban-elitist approaches of the past into a much more imaginative and vigorous rural-oriented approach. In this context my Ministry is working in close coordination with the Ministry of Information and Broadcasting, and is also trying to draw the best media talent available in the country into the structuring of the new programme.

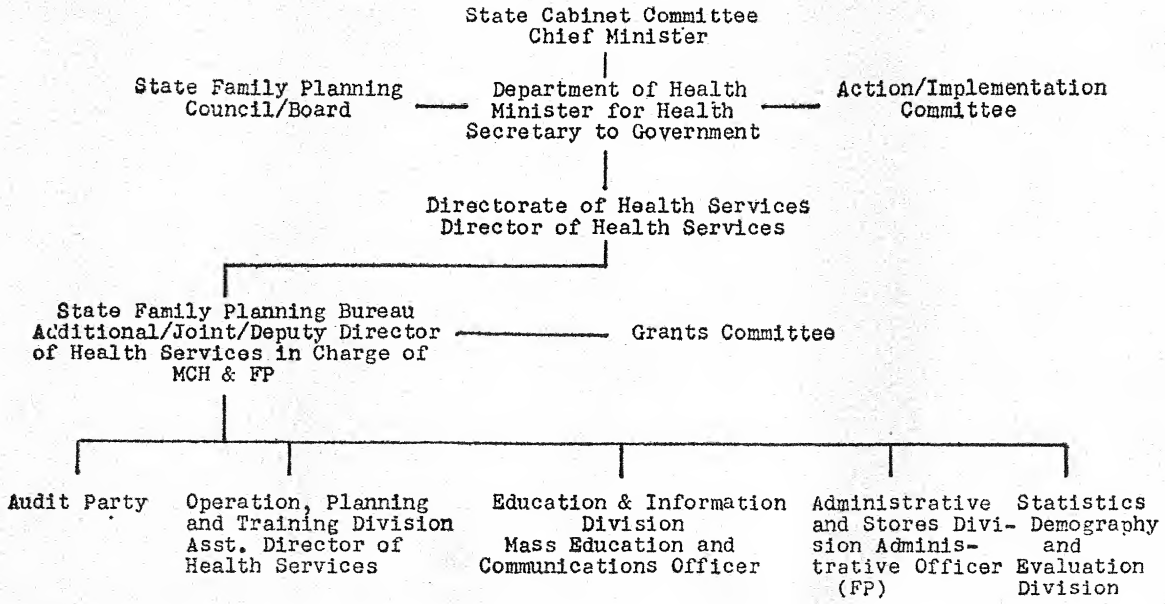
This package of measures will succeed in its objective only if it receives the full and active cooperation of the people ta large. It is my sincere hope that the entire nation will

strongly endorse the new population policy which, as part of a multifaceted strategy for economic development and social emancipation, is directed towards building a strong and prosperous India in the years and decades to come.

APPENDIX II

CHART - II

ORGANISATION FOR FAMILY PLANNING IN A STATE

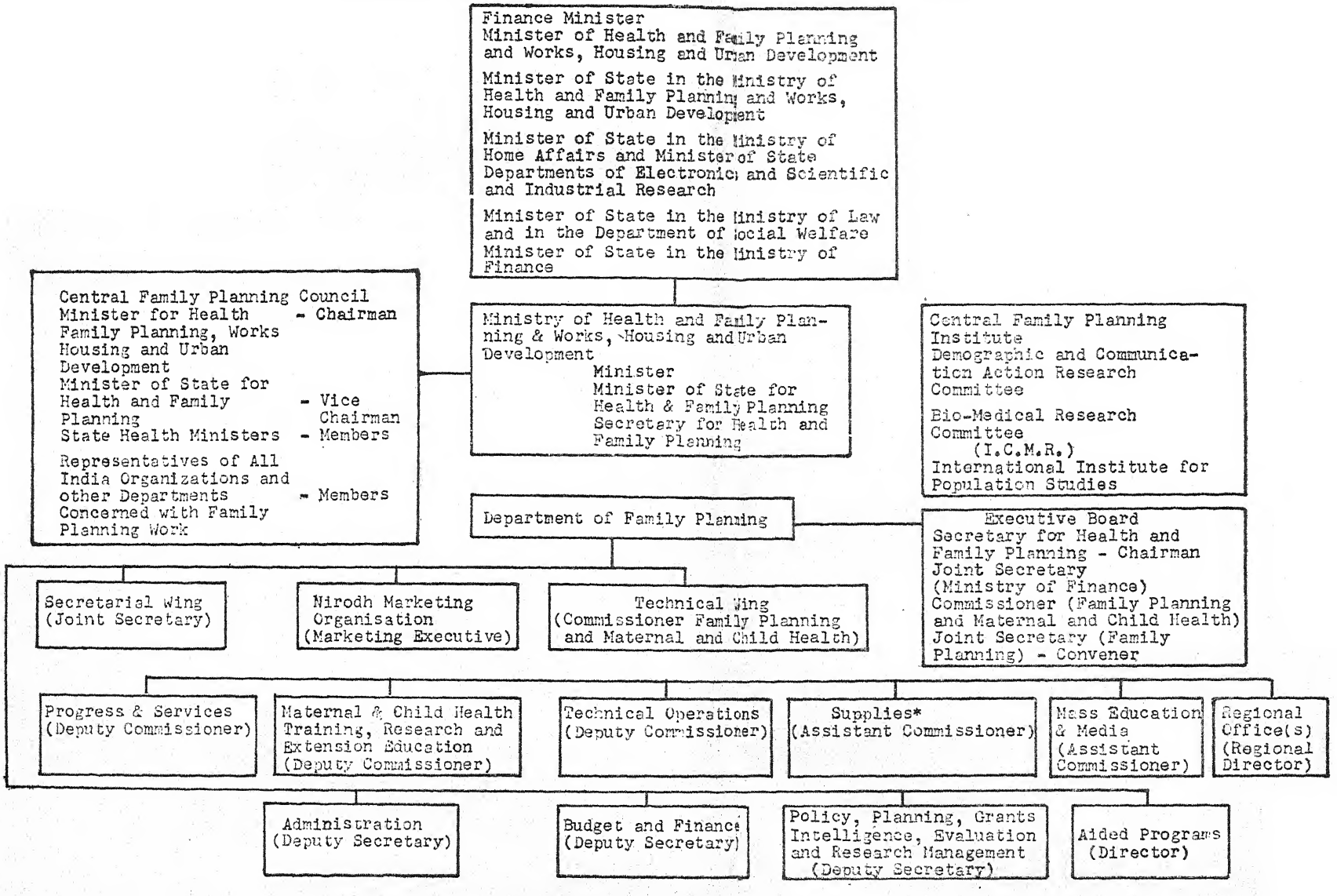


APPENDIX II

CHART I

I N D I A

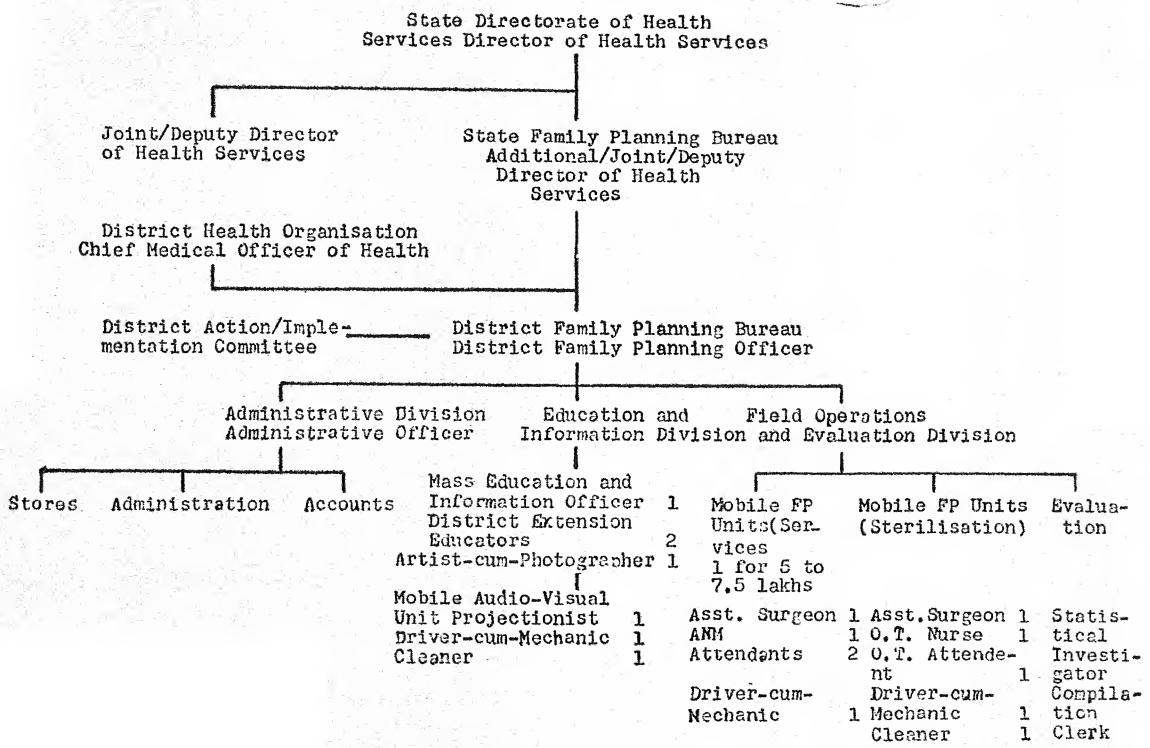
ORGANIZATIONAL CHART OF FAMILY PLANNING ACTIVITIES AT THE CENTER



APPENDIX II

CHART III

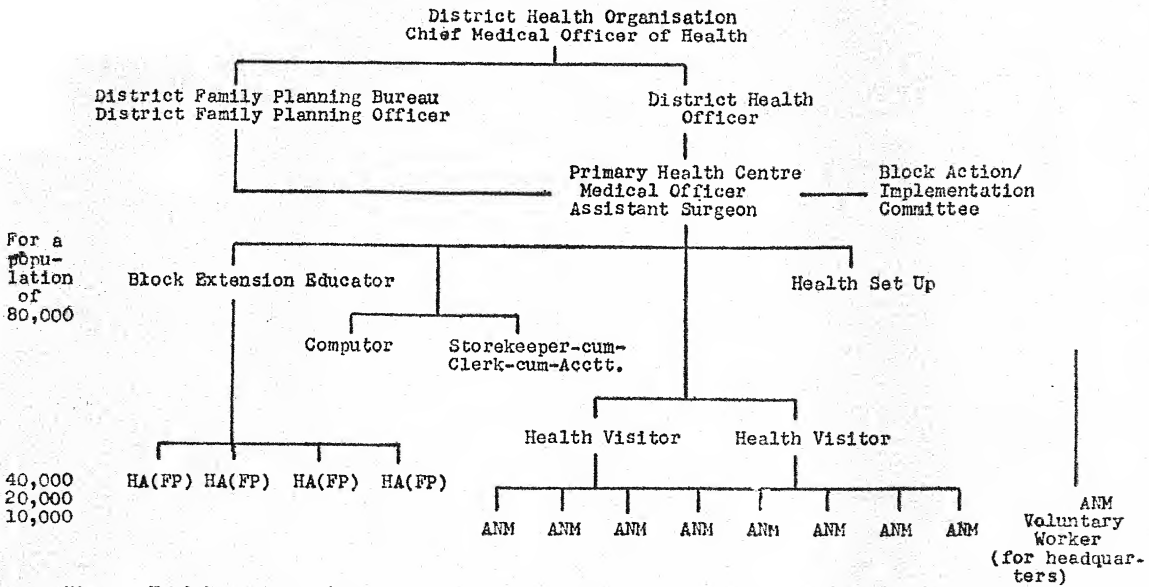
ORGANISATION FOR FAMILY PLANNING IN A DISTRICT



APPENDIX II

CHART - IV

ORGANISATION FOR FAMILY PLANNING AT A BLOCK



(HA = Health Assistant)

ANM = Auxiliary Nurse and Midewife

APPENDIX II

CHART V

ACTION/IMPLEMENTATION COMMERCIAL

I. At State Level		*II. At District Level*		*III. At Block Level*	
Chief Secretary	Chairman	Collector	Chairman	Chairman or President of Panchayat Samiti Union or Anchalik Panchayat	Chairman
Development Commissioner	Member	Chairman, Zila Parishad	Seven Members	Elected representative of the Samiti	Member
Health Secretary	Member	Civil Surgeon			
Other important State Officials	Members	District Planning Officer			
Director of M & HS	Member	District Health Officer		Block Medical Officer	Member
Regional Director	Member			FP Extension Workers	Members
Joint Director (FP)	Secretary	Other important District Officers and non-officials		Block Development Officer	Secretary
	District FP Officer				

APPENDIX III

TABLE 1

STATEWISE NUMBER OF COUPLES CURRENTLY PROTECTED AND THEIR PERCENTAGE TO TOTAL COUPLES IN THE REPRODUCTIVE AGE GROUP BY VARIOUS METHODS UP TO MARCH, 1973

Name of the State	*Estimated No. of couples in the reproductive age group (15-44) in March 1973 (in '000)*	*No. of couples currently producted*					
		Sterilisation		*IUD Insertions*		*C.C. Users*	
		No.	*% of couples protected*	*No.*	*% of couples protected*	*No.*	*% of eouples protected*
1. Andhra Pradesh	8410	1291587	15	52027	.6	51003	.6
2. Assam	2447	159788	7	32543	1	4976	.2
3. Bihar	11108	740795	7	102006	.9	16878	.1
4. Gujarat	4928	763768	26	42340	.9	72569	2
5. Haryana	1676	183563	11	79276	5	79128	5
6. Himachal Pradesh	664	39471	6	11799	2	3254	.5
7. Jammu & Kashmir	898	48650	5	18134	2	1662	.2
8. Kerala	3257	533116	16	82671	3	10598	.3
9. Madhya Pradesh	8421	942167	11	117779	1	79774	.9
10. Maharashtra	9573	2043748	21	61973	.6	142399	2

11.	Mysore	5243	513297	10	61091	1	32292	.6
12.	Orissa	4319	563115	13	126833	3	55551	1
13.	Punjab	2251	258115	12	135683	6	144941	7
14.	Rajasthan	5038	251105	5	53048	1	33614	.7
15.	Tamil Nadu	7622	1214862	16	91476	1	46274	.6
16.	Uttar Pradesh	17103	1010195	6	245488	1	74844	.4
17.	West Bengal	7632	777746	10	55749	.7	50728	.7
18.	Meghalaya	163	809	0.5	633	.4	448	.3
19.	Nagaland	72	226	0.3	38	.1	—	—
20.	Manipur	170	2167	1	4135	2	338	.2
21.	Tripura	288	14409	5	637	.2	2110	.7
22.	Andaman and Nicobar Islands	17	842	5	178	1	279	2
23.	Arunachal Pradesh	54	122	.2	232	.4	7	0
24.	Chandigarh	43	3267	8	2481	6	6031	14
25.	Dadra and Nagar Haveli	14	410	3	22	.2	211	2
26.	Delhi	710	65986	9	23139	3	150612	21
27.	Goa, Daman & Diu	130	10325	8	1464	1	2559	2
28.	Lakshadweep, Minicoy and Amindive Islands	6	183	3	20	.3	150	3
29.	Pondicherry	88	12889	15	5533	6	1412	2
30.	Ministry of Defence	—	44902	—	11028	—	35094	—
31.	Ministry of Railways	—	123152	—	13536	—	103992	—
32.	Comm. Distt.	—	—	—	—	—	1092778	—
	All India	102341	11614177	11.3	1432992	1.4	2316506	2.3

TABLE 2

BIRTH RATE AND SOCIO-ECONOMIC FACTORS—STATEWISE ANALYSIS

HIGH (UP TO 33 PER 1000)

Name of the State	*Birth rate per cent*	*Per cent of eligible couples protected*	*Urban population*	*Literacy rate per cent*	*Female literacy per cent*	*Per cent of population in agriculture*	*Mean age at Marriage (1961 census)*	*Growth rate 1961-1971*	*Population density*	*Average income per capita (Rs.)*
1. West Bengal	25	12	25	33	22	58	16	27	504	687
2. Kerala	30	19	16	60	54	48	20	26	549	555
3. Tamil Nadu	31	18	30	39	27	60	18	22	317	558
4. Mysore	32	12	24	32	21	65	16	24	153	552
5. Bihar	33	8	10	20	9	80	14	21	324	409
6. Maharashtra	33	23	31	39	26	64	16	27	164	686
7. Delhi	33	34	90	57	48	4	19	53	2738	—
8. Manipur	33	3	13	33	20	70	20	38	48	458
MEDIUM (i.e. 34—39)										
1. Jammu & Kashmir	34	8	18	19	9	67	16	30	—	426
2. Punjab	34	25	24	34	26	63	18	32	269	940
3. Andhra Pradesh	35	17	19	25	16	70	15	21	157	537
4. Tripura	36	6	8	31	21	74	16	36	149	532
5. Himachal Pradesh	37	8	7	32	20	76	16	23	62	585

6.	Assam	38	8	8	28	19	66	19	35	150	581
7.	Madhya Pradesh	39	14	16	22	11	78	14	29	94	458
					LOW (i.e. 40 and above)						
1.	Gujarat	40	18	28	36	25	65	17	29	136	667
2.	Haryana	42	20	18	27	15	66	—	32	227	810
3.	Rajasthan	43	7	18	19	8	73	14	28	75	455
4.	Uttar Pradesh	45	8	14	22	11	75	14	28	300	480
5.	Chandigarh	46	27	91	62	54	4	—	115	8257	—
	Total All India	37	15	20	29	18	69	16	25	178	551
					UNION TERRITORIES						
						HIGH					
1.	Goa, Daman & Diu	25	11	26	45	35	39	21	37	225	—
2.	Pondicherry	29	23	42	46	35	44	—	28	983	—
3.	Andaman & Nicobar Islands	31	7	23	44	31	19	17	81	14	—
4.	Lakshadweep Minicoy & Amindive Islands	33	6	—	44	31	—	—	32	994	—
5.	Manipur	33	3	13	33	20	70	20	38	48	458
							MEDIUM				
1.	Dadra and Nagar Haveli	36	5	—	15	8	89	—	28	151	—
2.	Tripura	36	6	8	31	21	74	16	36	149	532
3.	Arunachal Pradesh	38	1	3	11	4	86	—	39	6	—

• Figures rounded off to the nearest decimal.

TABLE 3

PHYSICAL TARGETS AND ACHIEVEMENTS

Item	Position as on 1-4-1969	Fourth Plan	
		Target (cumulative)	Achievement (likely)
1. District FP bureau	303	335	335
2. Rural FWP centres	4326	5250	5250
3. Rural sub-centres (Health & F.P.)	22826	31752	32217
4. Urban FWP centres	1797	1856	1952
5. (*a*) FP training centres (including central institutes)	48	51	49
(*b*) ANM training schools	337	391	342*
ANM training seats	—	1500	565
(*c*) LHV training schools		(sddl.)	
LHV training seats	18	22	25
6. No. of intensive districts to be covered	—	576	65
7. Post-partum centres	—	17	17
8. Indigenous production of Nirodh (million pieces)	—	59	124
9. Sterilisation beds	—	1200	600
10. Vehicles at RFWP centres at PHCs	951	4251	6000
	—	5000	2932

11. SHTO	—	18	NA
12. Medical officers (RFWPC)	NA	5225	2992
13. ANMS (health and FP)	20583	60000	50225
14. LHVs (health & FP)	3412	15700	10000
15. MCH programme			
(*a*) immunisation of infants and pre-school age children against diptheria, whooping cough and tetanus	—	72.50 lakhs	40.00 lakhs
(*b*) immunisation of expectant mothers against Tetanus	—	12.32 lakhs	9 00 lakhs
(*c*) prophylaxis against nutritional anaemia among mothers and children	—	180 00 lakhs	41.42 lakhs†
(*d*) nutritional programme for control of blindness among childern due to vitamin A deficiency	—	120.00 lakhs	31.24 lakhs†
No. of constructed Buildings			
16. Main centres	90	3357	2500
17. Sub-centres	360	11557	11800
18. Regional FP training Centres	3	37	26

* 54 ANM training schools had been discontinued in the beginning of the Fourth Five Year Plan.

† These figures are based on incomplete data.

TABLE 4

TARGETS AND ACHIEVEMENTS IN THE FOURTH PLAN

	Targets	*Achievements*
1. Sterilisation (million)	15	10
2. IUD insertions	6.6	2.4
3. Conventional Contraceptive users	10	4.1
4. No. of couples protected (cumulative)	28	19
5. Birth rate (per 1000 population	32	35

TABLE 5

TARGETS, ACHIEVEMENTS AND PERCENTAGE OF ACHIEVEMENTS OF TARGETS IN STERILISATIONS, IUD INSERTIONS AND CONVENTIONAL CONTRACEPTIVE USERS OVER THE YEARS IN INDIA

Years	*Sterilisations*			*IUD Operations*			*Con. Contraceptive Users*		
	Targets	*Achievements*	*Achievements per cent*	*Targets*	*Achievements*	*Achievements per cent*	*Targets*	*Achievements*	*Achievements per cent*
1966-67	1,253,354	887,768	70.2	4,198,797	909,726	21.7	2,308,272	464,605	20.1
1967-68	1,542,933	1,839,811	119.2	2,057,244	668,979	32.5	2,057,244	475,236	23.1
1968-69	2,108,543	1,664,817	79.0	790,716	478,731	60.5	2,108,543	960,896	45.6
1969-70	2,215,283	1,432,118	64.2	70,240	458,726	65.3	2,431,409	1,509,378	62.1
1970-71	2,600,000	1,329,914	51.2	900,000	475,848	52.9	4,800,000	1,962,347	40.9
1971-72	2,078,592	2,187,336	105.2	830,973	488,368	58.8	3,829,000	2,353,503	61.5
1972-73*	5,697,070	3,116,362	54.7	949,240	353,162	37.2	4,257,500	2,316,506	54.5

* Figures of achievements are provisional.

TABLE 6

STATEMENT GIVING M.C.H. SERVICES RENDERED UNDER THE POST PARTUM PROGRAMME DURING 1972-73

(Figures in lakhs)

S. No.	*Services rendered*	*1972-73*
1.	No. of ante-natal Mothers registered	7.10*
2.	No. of mothers visiting ante-natal Clinics	7.10
3.	No. of mothers visiting Post-natal Clinics	1.10
4.	*Children (delivered in hospitals) given :*	
	(*a*) Smallpox Vaccination	1.37
	(*b*) B.C.G. Vaccination	1.28
	(*c*) D.P.T. Immunisation	0.84
	(*d*) Polio Vaccination	0.77
5.	*Children (delivered elsewhere) given:*	
	(*a*) Smallpox Vaccination	0.23
	(*b*) B.C.G. Vaccination	0.39
	(*c*) D.P.T. Inoculation	0.67
	(*d*) Polio Vaccination	0.67
6.	Mothers immunised against Tetanus	2.18
7.	No. of Beneficiaries receiving Nutrition and ante-anaemic tablets	4.06

* 10 lacs = One Million

M.C.H. = Maternity and Child Health

TABLE 7

OUTLAY AND EXPENDITURE ON FAMILY PLANNING PROGRAMME OVER DIFFERENT PLAN PERIODS IN INDIA

(Rs. in lakhs)

Period	*Outlay*		*Expenditure*	
First Plan				
1951—56	65.00		14.50	
Second Plan				
1956-57			8.70	
1957-58			26.00	
1958-59	497.00		31.50	215.60
1959-60			51.00	
1960-61			98.40	
Third Plan				
1961-62			139.30	
1962-63			277.20	
1963-64	2,697.60		217.20	2,486.00
1964-65			652.30	
1965-66			1,200.00	
Annual Plans				
(Inter Plan Period)				
1966-67	1,493.00		1,342.60	
1967-68	3,100.00	8,293.00	2,652.30	7,046.40
1968-69	3,700.00		3,051.50	
Fourth Plan				
1969-70	4,200.00		3,618.42	
1970-71	5,200.00		4,890.43	
1971-72	6,060.50	28,576.20	6,175.56	28,003.96
1972-73	7,630,70		7,974.30	
1973-74	5,485.00		5,345.25	(Estimated)

Note: The figures of expenditure for 1966-67, 1967-68 and 1968-69 are based on grants released and that for 1969-70, 1970-71, 1971-72 and 1972-73 are based on departmental figures of expenditure as reported by States.

TABLE 8

FAMILY PLANNING PROGRAMME

ALLOCATIONED EXPENDITURE

(Rs. in lakhs)

Year	*Allocation*	*Expenditure*
1969-70	4200.00	3618.42
1970-71	5200.00	4890.43
1971-72	6060.46	6175.56
1972-73	7465.44	7619.93
1973-74	5345.00	5345.00
Total	28270.90	27649.34

TABLE 9

BREAK-UP OF PLAN OUTLAY (1969-74) FOR FAMILY PLANNING PROGRAMME IN INDIA

(Rs. in lakhs)

	1969-70	*1970-71*	*1971-72*	*1972-73*	*1973-74*	*Total*
1. Services	3,010.37	4,431.06	5,252.31	5,737,68	6,050.54	24,481.96
2. Training	254.93	366.25	263.10	274.29	276.43	1,335.00
3. Mass Education	325.66	270.96	285.20	297.01	325.21	1,504.04
4. Supply and Maintenance	248.62	432.72	532.32	570.89	631.45	2,436.00
5. Research:						
(*a*) Demographic & Communication	46.12	51.97	44.95	50.76	56.20	250.00
(*b*) Bio-medical	50.00	69.44	51.82	50.45	53.29	275.00
(*c*) N.I.F.P.	30.00	33.70	34.10	38.02	39.18	175.00
6. Evaluation	25.73	46.94	46.52	51.70	54.11	225.00
7. M.C.H.	47.77	38.85	47.70	59.25	71.43	265.00
8. Organisation	105 00	107.68	110.20	113.50	116.52	553.00
Total	4,144.20	5,749.57	6,688.32	7,243.55	7,674.45	31,500.00*

* In addition an agreement for an assistance of Rs. 1500.00 lakhs as detailed below has been signed with USAID during 1970-71.

	Rs. in lakhs
(i) Construction of Buildings for rural Main Centres and Sub-Centres and Regional Training Centres in insentive Districts and selected Areas and States of U.P., Bihar and West Bengal.	970.00
(ii) Intensive Districts and selected Area Programme in Second Phase.	330.00
(iii) Research and Evaluation.	200.00

TABLE 10

FOREIGN ASSISTANCE TO FAMILY PLANNING PROGRAMME IN INDIA
(AID SO FAR RECEIVED AND COMMITTED FROM COUNTRIES/INTERNATIONAL ORGANISATIONS)

Foreign Country/Agency	*Total assistance received and/Committed under the agreement (Rupees in lakhs)*	*Purpose*
(*1*)	(*2*)	(*3*)
1. United States USAID	3784.95	For various schemes like Training, Evaluation & Research, Intensive Districts, Construction, Vehicles, Community Assistance, Sterilisation Camps, innovative and experimental projects.
2. International Development Agency/Swedish International Development Agency.	2300.00	For special Family Planning and Nutritional programme in Uttar Pradesh and Mysore.

3.	Ford Foundation	746.25	Assistance to N.I.F.P. & N.I.H.A.E., West Bengal, D & E. Cell, Gandhigram Institute.
4.	UNFPA	141.24	Mass Vasectomy Camps, Travel Costs of Foreign Participants of AIIMS Seminar.
5.	UNICEF	136.48	For Strengthening ANM Training programme in U.P. and Bihar.
6.	Population Council, New York	92.2	For Fellowships on Biomedical Research and manufacture of loops.
7.	Norwegian Agency for International Department	88.27	For Post-partum programme.
8.	Japan	30.00	For purchase of condoms.
9.	Danish International Development Agency	25.21	For Constructing a building for NIFP.
10.	Swedish International Development Agency	13.64 plus (*i*) 324.9 million pieces of condoms (Nirodh) (*ii*) 20 printing units	

Continued

(1)	(2)	(3)
	(iii) 250 tons offset paper (iv) 500 tons of glazed newsprint	
11. W.H.O.	By ways of consultancy services followships and equipment	

In addition, negotiations are going on for one million pounds (£) from U.K. and 5 million dollars ($ from U.N.F.P.A.)

Total	—	7358.24

TABLE 11

INDIA'S CONTRIBUTION TO UNFPA & IUSSP

(*i*) United Nations Fund for Population Activities (UNFPA)

1971-72	Rs. 18.75 lakhs
1972-73	Rs. 18.75 lakhs

(*ii*) International Union for Scientific Study of Population (IUSSP)

Annual Contribution

1971-72 equivalent to $ 2,000
(Rs. 15,000 approx.)

1972-73 equivalent to $ 2,000
(Rs. 15,000 approx.)

TABLE I2

THE POSITION OF TECHNICAL STAFF AT VARIOUS LEVELS OF FAMILY PLANNING ORGANISATION (PERCENTAGE IN POSITION REQUIRED)

Name of the State	*State level (Percentage in position required)*	*District level (Percentage in position required)*	*Rural level (Percentage in position required)*	*Urban level (Percentage in position required)*
1. Andhra Pradesh	87	93	93	96
2. Assam	67	82	16	35
3. Bihar	80	93	35	74
4. Gujarat	87	91	63	20
5. Haryana	87	81	78	82
6. Himachal Pradesh	—	24	15	15
7. Jammu & Kashmir	67	60	33	60
8. Kerala	93	100	81	48
9. Madhya Pradesh	60	86	73	97
10. Maharashtra	67	74	47	43
11. Manipur	7	73	15	29
12. Meghalaya	7	77	16	39
13. Mysore	53	60	51	16
14. Orissa	80	80	58	69
15. Punjab	80	94	66	76
16. Rajasthan	107	58	71	90
17. Tamil Nadu	87	100	62	52
18. Uttar Pradesh	93	70	51	69
19. West Bengal	60	75	44	59
20. Delhi	46	—	39	89
21. Pondicherry	100	—	67	100
22. Tripura	—	89	25	133
23. Chandigarh	—	44	83	75
24. Dadra and Nagar Haveli	—	—	33	—
25. Goa, Daman & Diu	—	—	70	70

TABLE 13

NUMBER OF DIFFERENT CATEGORIES OF PERSONNEL TRAINED YEARWISE SINCE INCEPTION BY REGIONAL FAMILY PLANNING TRAINING CENTRES

	Category	*1968*	*1968-69*	*1969-70*	*1970-71*	*1971-72*	*1972-73*	*Total*
1.	Medical Officer	2813	1091	2084	2170	2067	1397	11586
2.	Block Extension Educators	2535	1515	967	1502	1071	1233	8823
3.	Lady Health Visitors	2080	1471	962	1136	1041	725	7415
4.	Health Assistants	3622	3233	3852	3279	3044	2216	19246
5.	Auxiliary Nurse Midwives	3341	3505	973	1391	2115	1636	21961
6.	Computers/Statistical Assistants	53	96	1047	459	679	358	2692
7.	Others	13723	9406	5361	5393	5703	5324	44915
	Total	28172	20317	15210	15330	15720	12889	107638

TABLE 14

NUMBER OF DIFFERENT CATEGORIES OF PERSONNEL TRAINED YEAR-WISE SINCE INCEPTION BY CENTRAL FAMILY PLANNING FIELD UNITS IN INDIA

Categories of personnel	*Since inception to 31-3-68*	*1968-69*	*1969-70*	*1970-71*	*1971-72*	*1972-73*	*Total*
(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*	*(7)*	*(8)*
Doctors	4,688	301	1,221	259	2,067	76	8,612
Extension Educators	4,096	526	326	25	1,071	160	6,204
Health Assistants/ Social Workers	2,279	1,903	1,122	742	3,004	994	10,084
Lady Health Visitors	2,607	1,018	659	360	1,041	317	6,002
Auxiliary Nurse/Midwives	4,463	3,916	4,992	3,661	2,215	2,516	21,763
Others	72,753	13,014	8,443	7,003	6,382	8,968	116,563
Total	90,886	20,678	16,763	12,050	15,820	13,031	159,228

Source: Training Section of the Department of Family Planning.

APPENDIX V

BIBLIOGRAPHY

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